

PASTORS AS CARING BRIDGE BUILDERS
IN HEALTHCARE SETTINGS

A Professional Project
presented to
the Faculty of
Claremont School of Theology

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Ministry

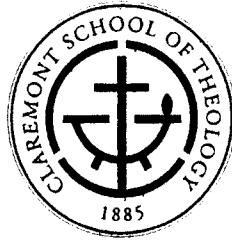
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May 2015

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has been presented to and accepted by the
faculty of Claremont School of Theology in
partial fulfillment of the requirements of the

DOCTOR OF MINISTRY

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ABSTRACT

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Juleun Andrew Johnson

The goal of this project was to assess the understanding of end-of-life care among Seventh-day Adventist pastors. It is argued that Seventh-day Adventist pastors who are not confident or well prepared for end-of-life care ministry may benefit from continuing education through a short educational module that may increase their confidence and knowledge. This thesis was tested through an educational webinar for pastors.

Data was collected from 12 participants. The majority of the participants were African-American Seventh-day Adventist pastors. Surveys taken prior to and following the webinar measured participants' understanding of end-of-life pastoral care principles. The pretest and post-test scores and comments were analyzed to measure understanding and the effectiveness of the seminar. After analysis, the results demonstrated the ministers' openness and desire for more education about end-of-life principles to enhance their parish ministries.

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DEDICATION

This project is dedicated to the Smith family and the Rising Star Seventh-day Adventist Church in Rolling Fork, Mississippi. Without you inviting me to be a part of your painful experience with Kim and her life-changing accident, this project would not have been possible. Thank you for allowing me to be a chaplain to your family before I knew what chaplaincy was. Your belief in me as a pastor from my first Sabbath with you helped me more than you would ever know. I will always be indebted to you for allowing me to serve your family.

Chapter One

Introduction

This project addresses the communication gap between medical professionals, African American patients, and spiritual care providers that can be a barrier to effective healthcare.

My interest in this topic emerges from my own ministerial experience. It has been my privilege to have served 14 years as a Seventh-day Adventist assistant pastor and solo pastor in both rural and urban contexts. My ministry has taken me to Alabama, Florida, Illinois, and Mississippi. I have served after horrific natural disasters as a chaplain and spiritual care provider. My formal chaplaincy experience includes working as a Clinical Pastoral Education (CPE) student and a chaplain at the University of Alabama at Birmingham (UAB) Hospital in Birmingham, AL, and as a chaplain at Florida Hospital in Orlando, FL.

During my ministry in churches and hospitals I have encountered people who have misunderstood or are confused about a medical diagnosis. Some of these patients and parishioners have received important health information. I have observed individuals who have nodded to show their comprehension in the presence of physicians, only to wonder what was said once the physicians left. Those situations indicate that increased medical understanding on the part of spiritual caregivers may result in better-equipped religious leaders. An increased awareness could also assist in providing more meaningful spiritual care at times of birth, crisis, surgery, withdrawal of support, end of life, and death.

As a pastor in both rural and urban settings, I have served as a bridge for understanding with both patients and parishioners. I hope to equip professional and lay spiritual care providers in their distribution of effective spiritual care in clinical settings. This assistance is provided through the project-based research that will be discussed in Chapter Four.

As a spiritual care advisor, it may also be useful to have a resource to help a patient or parishioner experience decreased anxiety. It is my goal to provide guidelines for end-of-life care during and after a crisis. These guidelines may include coping strategies, definitions of key terms, and liturgical resources. This research may also provide helpful information for those who are not able to attend clinical ministry programs because of time or proximity.

Thesis

Seventh-day Adventist pastors who have not received formal training in end-of-life care ministry may benefit from continuing education through a short educational module that may increase their confidence and knowledge.

Definitions of Terms

Several key terms are listed below. The terms that have been chosen represent identifying marks of this project. The following terms are defined: *regional conferences*, *spiritual care providers*, and *healthcare settings*. The terms have been chosen to illuminate a reader's understanding and provide an understanding of my primary context of ministry.

Regional Conferences

Regional conferences are Seventh-day Adventist conferences administered

primarily by those of African-American or African-Caribbean descent. These conferences, while mostly populated by those of African-American and African-Caribbean descent, include groups of people from all languages and nationalities. There are nine regional conferences in North America.

Spiritual Care Providers

The use of the term, *spiritual care providers*, is primarily limited to pastors and elders in the Seventh-day Adventist Church. The aforementioned group is responsible for the growth and nurture of local parishes. Spiritual care providers may also include administrators, chaplains, departmental directors, and faculty on college and university campuses.

Health Care Settings

The term, *health care settings*, will be limited to crisis and end-of-life care centers. These care centers may include hospitals, hospices, nursing homes, and rehabilitation facilities. These health care settings are places where family members may be confronted with end-of-life care decisions for loved ones.

Work Done Previously in the Field

In relation to healthcare, communication is vital. The interchanges between patients and physicians are important in the healthcare encounter. In their literature review, L. M. L. Ong, J. C. J. M. De Haes, A. M. Hoos, and F. B. Lammes address the importance of doctor-patient communication. Their article articulates the needs of doctors who have researched doctor-patient communication with cancer patients. They note that there are some inherent barriers to overcome. One barrier mentioned is the

language barrier between everyday language and medical language.¹ A person not familiar with medical language may be at a deficit for understanding treatment plans or options for care because of medical jargon. In circumstances where communication is a critical, it may be necessary to clarify necessary healthcare information through a cultural broker.

Pastors may serve as cultural brokers to their communities. This idea is highlighted in the following chapters through the work of Harold Koenig and other researchers. Pastors may be privy to customs, traditions, and ways of life that may impact the care of parishioners in healthcare settings. Pastoral brokers who have an understanding of healthcare vocabulary may assist in providing both religious and healthcare understanding to church members.

A pastor functioning as a cultural broker has many benefits. The hospital benefits from having a greater positive impact in the communities served by the institution. A key benefit of having a cultural broker in a healthcare setting is a decrease in the return rate based on a lack of understanding of the treatment plan. This understanding would potentially save insured and uninsured patients time and money.² Patients benefit from having received treatment that is religiously and culturally in line with their values and principles.

Although some parishioners only have contact with their pastor on their day of

¹ L. M. L. Ong et al., "Doctor Patient Communication: A Review of The Literature," *Social Science Medicine* 40, no. 7 (1995): 903-918.

² National Center for Cultural Competence, Georgetown University Center for Child and Human Development, *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs* (Washington, DC: Georgetown University Medical Center, 2004), 8.

worship, all people will encounter some life event or crisis that requires spiritual care. Each worshipping community expects their minister to participate in the events of the cycle of life, whether grim or joyous. In 1967, Holmes and Rahe concluded that there were at least ten traumatic life events.³ In a follow-up study in 2001, Spurgeon, Jackson, and Beach included those traumatic life events in their findings and added other current life challenges.

The traumatic life events included (i.) death of a spouse, (ii.) jail sentence, (iii.) death of immediate family member, (iv.) immediate family member commits suicide, (v.) getting into debt beyond means of repayment, (vi.) period of homelessness, (vii.) immediate family member seriously ill, (viii.) unemployment (of head of household), (ix.) divorce, and (x.) break-up of family.⁴

Experiencing any combination of these life events may affect a person's physical and mental health. One goal of the spiritual caregiver is to assist in providing support for spiritual and emotional challenges. It is unrealistic to think that every person reacts in the same way to a particular type of event. While some people in the aforementioned categories may experience support, others may not.

A key connectional figure in the midst of a crisis is a clergyperson. The role of the caregiver fluctuates with each ministry encounter, which may include listening, confrontation, encouragement, and reconciliation. Each pastoral care scenario, whether long or brief, depends on the person's story. John Savage, in his book, *Listening and Caring Skills in Ministry*, shares effective methods useful to both paid and volunteer

³ Merely Me, "Top Ten Stressful Life Events as Predictors of Mental and Physical Illness," *Health Central*, accessed October 27, 2013, <http://www.healthcentral.com/anxiety/c/157571/115211/life-predictors>.

⁴ A. Spurgeon, C. A. Jackson, and J. R. Beach, "The Life Events Inventory: Re-Scaling Based on an Occupational Sample," *Occupational Medicine* 51, no. 4 (2001): 287-293.

ministers. Savage states that key listening skills are vital components to understanding and experiencing a person's story.⁵

According to Brian Childs in his work, *Short-Term Pastoral Counseling*, pastors have the opportunity to assist parishioners with resources based on their relationship as pastor and congregational member.⁶ This relationship is vital to crisis ministry. It is possible that, with proper training and continuing education, pastors could function as effective advocates for the patients in their congregations.

In my view, the pastor has a significant role in not just emotional healing, but also in facilitating quality spiritual care on a continual basis. From the very moment that a crisis happens, a person has the opportunity to be connected to a clinically-trained care provider in many hospitals. However, after the patient is discharged, who continues the spiritual care? It is possible that some people do not have a minister, but those who do may not have a relationship with their minister.

One of the key challenges in pastoral care and counseling is having ministers who are educated in meaningful care. Loren Townsend asserts that, in many religious contexts with clinically-trained chaplains, people still rely on their pastors.⁷ It may not seem obvious, but despite a chaplain's training, some people may not feel comfortable with a "stranger" during their crisis. At the same time, others may feel comfortable

⁵ John Savage, *Listening and Caring Skills in Ministry* (Nashville: Abingdon, 1996), 79.

⁶ Brian Childs, *Short-Term Pastoral Counseling: A Guide* (Nashville: Abingdon, 1990), 21.

⁷ Loren Townsend, "Fermentation and Training in Clinical Ministry," in *Pastoral Care and Counseling: Redefining the Paradigm*, ed. Nancy J. Ramsay (Nashville: Abingdon, 2004), 124.

talking to a perfect stranger about a disease or diagnosis they would not desire a parish minister to know. One challenge in providing effective clinical care is the challenge of access to training programs. Townsend notes that “[clinical] training programs are rarely accessible to parish pastors . . .”⁸ Some seminaries offer training programs to pastors in the field of pastoral care. However, some seminaries do not have programs with trained faculty who can offer clinical spiritual care training.

Today, more than ever, there are many denominations that have shifted to employing bi-vocational pastors. People in both urban and rural settings deserve meaningful pastoral care. While many bi-vocational pastors administer sacraments, it is possible that some pastors may miss out on the benefit of vital seminary educational opportunities. Beyond the camaraderie, faculty, and library resources, a key component to the seminary experience is field education. In seminary, field education plays an important role. It affords seminarians the opportunity to have on-the-job training for future ministry endeavors. Virginia Cetuk writes that field education invites seminarians to engage in a process of reflection on meanings and values that should be translated to the parish upon graduation.⁹

In this project, I propose that a seminar that may serve as a continuing education module for ministers. The proposed seminar serves as a link in the field education that Cetuk advocates. There are several reasons why I feel the seminar addresses the problem of communication in healthcare settings. First, the communication of skills would give parish ministers insights into the language of the clinical environment. Second, the

⁸ Townsend, *Fermentation and Training*, 124.

⁹ Virginia S. Cetuk, *What To Expect In Seminary: Theological Education as Spiritual Formation* (Nashville: Abingdon, 1998), 139.

seminar addresses end-of-life concerns. Death and grief are a part of the cycle of life at home and in the church. Education for pastors may assist them in the continuity of care for patients and families after discharge. Finally, among Seventh-day Adventist ministers, introduction to end-of-life care is not done in undergraduate or graduate theological education. This concept will be further expounded upon in the next chapter.

Assessment is another component of spiritual care that may be helpful for parish pastors. Assessments assist ministers in communicating with grief-stricken families and providing support. Ministers are called to serve people at birth and during crises. David Switzer, in his book, *The Minister as Crisis Counselor*, states that ministers must be able to assess and triage the critical needs of people in crisis.¹⁰ Assessments provide information and unearth the hidden gems of the story of a patient or parishioner.

Advantages of assessment are limitless. A primary use of the assessment is to identify the ministry areas of emphasis at the moment. Where is the real pain? Is the pain physical or is it also emotional? Does the patient or family have support? What does meaning look like in this moment? These questions are components of assessments that would assist in providing meaningful ministry in crisis.

Scope and Limitations

This project is limited to pastoral care in end-of-life situations and crises. Although this research may be useful to all those in Christian ministry, the project will be conducted among African-American clergy involved in Seventh-day Adventist ministry. One of the primary limitations to this project is that the long-term influence of the

¹⁰ David Switzer, *The Minister as Crisis Counselor* (Nashville: Abingdon, 1989), 149.

training is not assessed, discussed, or included. The seminar provides meaningful content and assesses the usefulness of the material to the participants' ministry contexts. In addition to the survey, an open-ended assessment was conducted via a comments section at the end of the survey.

Despite the lack of denominational resources on pastoral care, I examined and explored existing Seventh-day Adventist tools for assisting pastors in clinical pastoral care scenarios. This work seeks to be pragmatic and useful for everyday challenges in ministry. It is my desire that the research presented will lead to meaningful ministry at the bedside and in the pew.

Procedure for Integration

This project engages both the theory and practice of ministry. This will include qualitative research and library research to facilitate integration of theoretical and practical elements of the project. I engage scholars and works of those in the field of parish and pastoral care ministry. An examination of historical and sociological issues as it relates to care will be explored. This work includes a brief discussion of the Seventh-day Adventist Church's history of ministers and ministerial training. My hope is to introduce possible methods of integrating the research findings into the parish and clinical setting. By developing critical elements of the research, my desire is that a new paradigm may be explored in my religious context.

The research required me to select a target group for research and to construct and distribute appropriate questionnaires. Selection of the target group included research through social media pastors' forums that include Seventh-day Adventist ministers. I solicited participation through *Facebook* and other social media outlets. A goal for the

project was to have at least 10-15 pastors participate in the research. Prior to the seminar, each eligible participant signed and emailed me a copy of their informed consent form, which indicated their willingness to participate in this research project.

The methods of evaluation included a pretest prior to the seminar and a post-test following the seminar. The post-test assessed the learning of the participants. An open-ended comments section was placed at the end of the survey so participants could share the usefulness of the training to their ministry context. The goal of the seminar was that it would assist in orienting pastors to be more effective in crisis and end-of-life care ministry.

The seminar aided in challenging and increasing the awareness of parish pastors about crisis and end-of-life care experiences in clinical settings. One goal was that clinical spiritual care skills included in this seminar would be useful to parish ministers. Pastors attended this workshop via a recorded YouTube presentation. This method of providing the seminar was cost-effective and manageable for time constraints. Participants responded using electronic surveys available through Survey Monkey, which made use of technology and was easy for the respondents to use.

Chapter Outlines

A guiding factor in the discussions in the chapters to follow is scripture. Why use the Bible and not liberation theology or another theological perspective? For both Seventh-day Adventists and African-Americans, the Bible has served as a primary source for encouragement, guidance, and hope. African-Americans throughout the ages have grounded their faith and beliefs during end-of-life situations in a view toward heaven. The psalms, hymns, and spiritual songs of the African-American experience are based on

overcoming and relief from present circumstances. These experiences are rooted in scripture.

Seventh-day Adventists are Bible-believing Christians. Their beliefs are rooted in the work of Christ on the cross of Calvary. Also key in their belief system is Christ's immanent second coming. While both African-Americans and Seventh-day Adventists are concerned about life today, they are also aware of a desire for an eternal heavenly home. Both experiences are based in scripture, which aids in daily living and implementation of spiritual values. The work of the pastor is based on scriptural imperatives. In both the Seventh-day Adventist (SDA) and African-American contexts, pastors serve as key figures, a role which will be highlighted later in this document.

Despite the SDA emphasis on healthcare and education, an early African-American leader died because she did not have access to health care.¹¹ This prompted a reform of the denomination. However, aspects of segregation and unequal access still plague the church; one example is poor ministerial preparation for ministry at the time of death. This project attempts to build on Lucy Byard's legacy by providing additional leadership and training about health care issues to African-American SDA pastors. It creates awareness and calls for more effective education, understanding, and implementation of end-of-life care principles for pastors and other non-parish clergy.

This project serves to repair the breach in understanding. Public practical theology serves as a framework for this project. Richard Osmer describes the four tasks

¹¹ Louis B. Reynolds, *We Have Tomorrow: The Story of American Seventh-Day Adventists with an African Heritage* (Hagerstown, MD: Review and Herald, 1983), 293-294.

of public practical theology and poses them as questions. Thus, public practical theology seeks to understand “(1) What is going on? (2) Why is this going on? (3) What ought to be going on? (4) How might we respond?”¹² While Osmer’s questions are not the only questions that offer insight into practical theology, they are important.

In response to Osmer’s questions, this project serves as a beacon to illuminate the need for effective end-of-life care awareness and training. This effort shares research based on the relationship of Seventh-day Adventist ministers to end-of-life care. The study highlights the figure African-Americans consider a primary conduit for community action and engagement—the minister. The answer to why this is going on is addressed through an examination of the educational and ministerial focus in Seventh-day Adventist church history. The answer to what should be going on is illustrated through the survey’s data and analysis. The response is highlighted through a view of the realistic opportunities and the challenges to implementing these findings in Christian communities.

This first chapter has identified the thesis, the problem addressed by the project, the importance of the problem, definitions of major terms, work previously done in the field, the scope and limitations of the project, and the procedure for integration.

The second chapter shares a history and overview of Seventh-day Adventist ministry and healthcare. It describes the Seventh-day Adventist church structure as it relates to parish ministry. The chapter also addresses biblical imperatives for a ministry of care and theological foundations for pastoral care. Biblical aspects of care are

¹² Richard R. Osmer, *Practical Theology: An Introduction* (Grand Rapids, MI: William B. Eerdmans, 2008), 4.

identified from the Old and New Testaments. Practical aspects of spiritual care giving will also be explored.

The third chapter focuses on a personal theology of pastoral care with a practical basis for the need for pastoral care. A main topic to be explored will be differentiating clinical spiritual care from parish spiritual care. This chapter addresses the obstacles and challenges a caregiver brings and encounters during an end-of-life care scenario. The chapter also discusses major theological issues in pastoral care.

The fourth chapter provides a narration of the project and its results. This includes a project overview, a description of its implementation and results, and a summary. The aim is to provide the reader with the data collected, the results, and their uses for ministry. The project is a reflection of theory and the study's contribution to the pastoral care conversation.

The final chapter will be the conclusion. I will offer my reflections on and insights into what I have both studied and learned. I will also make recommendations based on the data and invite continued dialogue on this subject.

This project offers reflection, dialogue, and research with authors regarding end-of-life care. Special attention will be given to theology, culture, and community. Pastors serve as primary figures in end-of-life care conversations. The research presented shares pastors' awareness and desires to become more effective catalysts in end-of-life care discussions.

Chapter Two

Religious, Cultural, and Communal Imperatives for a Ministry of Care

Ministry is a dynamic profession. Clergy are called to be shepherds, prophets, and priests. Development of the shepherding skill requires time, dedication, and perseverance. The same skills are needed to develop and thrive while offering a ministry of care. While pastors serve as leaders, they are also catalysts for change in their communities. Historically, the church community and pastors have aided in fusing generational gaps. The church offers unlimited and untapped potential through effective community partnerships and resources.

Seventh-day Adventist Church History

The Seventh-day Adventist Church arose out of the Great Awakening in the New England states during the 1840s. The ministry of William Miller, a founder and proponent of this movement, revolved around his belief that Jesus was coming during his lifetime.¹³ Many religious groups and individuals that occupied the New England states studied biblical prophecies to ascertain if this were true.

One group of people believed they had found biblical evidence that Jesus would return on October 22, 1844.¹⁴ In hopes that Christ would come, many people sold all their possessions and worldly goods. When Christ did not appear, scores of these stalwart supporters lost hope and faith in these teachings. While many once enthusiastic participants faded away, a group kept studying and believing that Christ would come.

¹³ L. E. Froom, *Lightbearers to the Remnant: A Denominational History Textbook for College Students* (Washington, DC: Review and Herald, 1979), 49.

¹⁴ "United for Mission," General Conference of Seventh-day Adventists, accessed October 5, 2014, <http://150.adventist.org>.

Out of this new band of believers, many teenage and young adult Methodists would arise as early leaders. Seeking principles for governance and organizing, these early leaders leaned on their Methodist heritage. Thus, the governance and organizational structure of the Seventh-day Adventist Church mirrors that of the United Methodist Church.

The Seventh-day Adventist Church was organized in 1863 in Washington, New Hampshire. The name of the church was the result of much Bible study and prayer. The “Seventh-day” part of the name refers to the seventh day of the week, Saturday, as a day of rest. The “Adventist” portion refers to the hope of the 2nd Coming of Jesus Christ. The structure of the church includes churches, conferences, unions (of conferences), world divisions, and a General Conference. The headquarters for the church was once in Battle Creek, Michigan, then Washington, D.C., and finally, it moved to Silver Spring, Maryland. This once small group of believers who could fit in a small wooden church now boasts nearly 19 million members today.¹⁵

Consistent with its message of the coming of Jesus Christ was the emergence of health reform. The early Seventh-day Adventist movement was birthed during the time of the women’s suffrage movement and the abolition of slavery.¹⁶ Coinciding with both of these dynamic and world-altering concepts at the time was the health movement. Early Adventist health proponents included James and Ellen White, John Byington, and John Harvey Kellogg, who created healthy breakfast meal options, including cereal. Sanitariums for treating illness and creating environments for holistic healing are

¹⁵ “Quick Statistics on the Seventh-day Adventist Church,” General Conference of Seventh-day Adventists, accessed October 5, 2014, <http://www.adventistarchives.org/quick-statistics-on-the-seventh-day-adventist-church#.VDF45UviJqk>.

¹⁶ Froom, *Lightbearers*, 20.

consistent with the message of the Seventh-day Adventist Church. Beginning with one sanitarium in Battle Creek, Michigan, and spreading to six continents, the church now operates nearly 614 hospitals, sanitariums, nursing homes, orphanages, and clinics.¹⁷

Regional Conferences

The Seventh-day Adventist Church is one of a few denominations that was founded in America. Parallel with this fact is that the church kept the vestiges of its historical surroundings, which included segregation. Seventh-day Adventist churches were segregated based on skin color in the early days of the denomination. Although founded during the abolitionist movement, the church maintained a separate but equal status for black persons. Freed slaves and their descendants joined the church in rapid numbers. However, even near the turn of the 20th century, black pastors were not represented proportionately to black membership in leadership.

The leadership structure of the denomination was altered based on the case of Lucy Byard. Lucy Byard was an African-American Seventh-day Adventist woman who was denied medical care at a Seventh-day Adventist hospital and subsequently died.¹⁸ Byard's death caused the world church leadership to become conscious of the need for institutions and a leadership structure that gave blacks a direct opportunity to lead. Today, regional conferences provide significant financial and leadership support to the Seventh-day Adventist church's world mission.

Healthcare

The Seventh-day Adventist church has a broad approach to healthcare. The

¹⁷ Froom, *Lightbearers*, 20.

¹⁸ Reynolds, *We Have Tomorrow*, 293-294.

church operates orphanages and retirement homes. A portion of the rationale for SDA healthcare is based on two biblical concepts: ministry to the known and to the stranger. Ministry to the known is based on the words of Jesus in Matthew 25:31-46. Jesus speaks of the stranger who is sick, in prison, and naked. The mandate of Jesus is that his followers will clothe, visit, and encourage others. The concept of ministry to the stranger comes from Hebrews 13:2, which says, “Do not forget to show hospitality to strangers, for by so doing some people have shown hospitality to angels without knowing it.” The goal of the concept is not to show partiality, but rather, it is to minister to people as if one were serving holy angels.

Seventh-day Adventist Pastor Training and Formation

Higher educational training became a need for pastors around the turn of the 20th century. In 1892, the goal of training professional pastors in the Seventh-day Adventist Church was formally adopted.¹⁹ O. A. Olsen, then the world church president, had a passion to see pastors as professionals. A fear was that, without formal education, ministers might lose credibility inside the church and out in the community at large. Schools were strategically established in regions of the United States and around the world for the training of ministers and medical missionaries. Many of these original schools continue to provide education to scores of ministers today.

From the inception of the church, pastors had several responsibilities. Pastors in the Seventh-day Adventist Church serve as shepherds, evangelists, teachers, and primary sources of contact for local church community affairs. Persons serving in positions of

¹⁹ Richard W. Schwartz and Floyd Greenleaf, *Light Bearer: A History of the Seventh-Day Adventist Church*, rev. ed. (Nampa, ID: Pacific Press, 2000), 387,388.

church leadership at other levels of the church are responsible for governance and programs. A. G. Daniells, an early world president of the Seventh-day Adventist church, named three primary functions of all ministers. Froom reflects on Daniells' view of ministerial success, which included (1) success in winning individuals to Christ and his church, (2) effectiveness in establishing these new converts in basic biblical doctrine, and (3) an ability to get church members to actively and joyfully support church projects with their time and money.²⁰

Even though Daniells' advice is over 100 years old, it continues to be the hallmark of ministry in the Seventh-day Adventist church. An issue that I have with this philosophy of ministry is that for generations ministry has been about numbers and not about people. This philosophy has little if anything to do with nurture. If a minister is educated only in theology, evangelism, and church history, and not in nurturing individuals, he or she may become a theological robot.²¹ Not only will the minister's rhetoric tow the company line, but it will produce pastors who care more about numbers than people. Many potential churchgoers seek a place of hope, healing, and wholeness. Pastors must be properly educated in aspects of nurture to meet these needs.

My contention is that the nurturing aspect of pastors' development begins with theological education. Once pastors in training are exposed to nurturing classes at the undergraduate level, they may be more prone to provide effective care in parishes.

²⁰ Froom, *Lightbearers*, 484.

²¹ At the time of my own attendance at seminary, I was only required to take two classes on pastoral care and counseling. One was focused on pastoral care in general, and the other one centered on listening. I contend that more theological education needs to be concentrated on nurture if people are planning to serve in a ministerial capacity that includes pastoring, teaching, or chaplaincy.

Seventh-day Adventist theological education is driven by the goal of being relevant and theologically sound. I agree with this motif. Pastors, teachers, and biblical scholars should be well-equipped to exegete and parse. Nonetheless, classes related to nurture would serve as valuable assets to an existing curriculum.

According to the Seventh-day Adventist International Board of Ministerial and Theological Education, only three courses are suggested for ministers in the area of nurture. These courses are Pastoral Care and Counseling, Pastoral Ministry, and Marriage and Family.²² Other courses more relevant for ministry must be taken at an individual's own cost in order to gain another specialty in ministry. Based on the fact that ministers in the parish are engaged with people first, it may be more relevant to offer communication and personality classes in basic theological education formation. This idea may face challenges in terms of accreditation, but it would be well worth investigation and implementation.

Clinical Ministry

Another educational focus in theological education that sometimes goes unnoticed is clinical ministry. A clinical ministry focus would aid in developing the nurturing aspect of ministerial training. Many clinical ministry programs are associated with Seventh-day Adventist hospitals. These programs speak to the education and formation of persons and their religious identities. If formation of persons and assurance of their religious identities does not occur in undergraduate programs, where does it happen?

An exceptional aspect of clinical ministry is clinical pastoral education (CPE).

²² International Board of Ministerial and Theological Education, *Handbook of Seventh-Day Adventist Ministerial and Theological Education* (Silver Spring, MD: General Conference of Seventh-day Adventists, Department of Education, 2001), 36.

CPE offers orientation to the personal and psychosocial aspects of end-of-life and crisis care in real time. While all theological education is beneficial for instruction and teaching, all may not be practical. Early exposure in ministerial training to crisis care and end-of-life care situations may be more prevalent than some higher critical theological queries. Clinical ministry may also serve as a viable option for those who are not offered a job as a pastor straight from seminary. In a recent conversation I found out that only 40% of seminary graduates of the Seventh-day Adventist Theological Seminary at Andrews University receive jobs.²³ Providing an introduction to and education in clinical ministry may be another way to help qualified and educated ministers find employment.

Pastoral Roles in End-of-Life Care Planning

Advanced Directives

End-of-life care preparation may be useful in ministerial training and in the life of the local parish. There are many things that people can do to prepare themselves for end-of-life care situations. These methods of preparation may include creating a last will and testament, funeral planning, and advanced directive planning.

Advanced directives serve as tools to assist persons who are in good health and in critical condition. They are legal documents a person fills out that aid in planning end-of-life wishes in case the person is deemed medically incompetent or is unable to

²³ Michael Polite (Associate Chaplain), in discussion with the author, November 2014.

communicate.²⁴ According to a recent study published in *The American Journal of Preventative Medicine*, 26.3% of the 7,900 people surveyed had advanced directives. Lack of awareness was cited as the most common reason a person did not have an advanced directive.”²⁵ The church can be a preparation place for assisting people with advanced care and end-of-life planning through community awareness events.

African-American Pastoral Influence on End-of-Life Care

Churches and their pastors are poised to create momentum in any cultural or social movement. Many significant moments in the African-American Christian community involve the community at large. From rituals such as baby dedications, baptisms, and communions to celebrations such as graduations, weddings, and funerals, African-Americans experience these pivotal moments in life together.

Pastors are centerpieces in the African-American church and community. Clergy are positioned to serve as key figures in facilitating community initiatives and conversations. The end-of-life conversation is important to churches and communities. The results of the aforementioned study conducted by Jaya Rao, Lynda Anderson, Feng-Chang Lin, and Jeffrey Laux led to their conclusion that “advanced directive completion was associated with older age, more education, and higher income and was less frequent among non-white respondents.”²⁶ This finding is very significant as it relates to all non-whites and specifically, African-Americans. If lack of awareness is cited as the reason

²⁴ “New Study on Advanced Directives,” National Hospice and Palliative Care Organization, accessed October 7, 2014, <http://www.nhpco.org/press-room/press-releases/new-study-advance-directives>.

²⁵ Jaya K. Rao et al., “Completion of Advanced Directives among U.S. Consumers,” *American Journal of Preventive Medicine* 46, no. 1 (Jan. 2014): 65-70.

²⁶ Rao et al., *Advanced Directives*, 65-70.

for people not planning for end-of-life care, then the catalyst and follow-through for creating awareness is the African-American church. The church has been the hub of activity and the center of religious and social life for many African-Americans.

In many African-American religious expressions, the pastor is held in high esteem. Notwithstanding the nomenclature of the pastor, many African-American Seventh-day Adventist churches function similarly culturally. There is a high respect for God, and the pastor is held in high esteem. Barnes notes that “pastors in the Black tradition have generally had great influence on the theological tenure and organizational structure of their churches. Better educated pastors tend to have the increased human capital higher education affords to train, develop, and implement social programs by mobilizing congregants and community.”²⁷ Since the black church is the centerpiece of religious, and at times, cultural life, the pastor may influence culture but may not understand the relevance of end-of-life planning.

Many Seventh-day Adventist pastors preach about the immanent 2nd Coming of Jesus Christ, but they may not share the same urgency in encouraging congregants to make advanced care plans. I am in agreement with Barnes’s article that the pastor has the forum to encourage, cajole, and rally the congregation on both theological and organizational levels. Many Seventh-day Adventist clergy hold master’s degrees. Graduate theological education is becoming a standard for entering Seventh-day Adventist ministry.²⁸ However, are pastors committed to social problems that plague the

²⁷ Sandra Barnes, “Priestly and Prophetic Influences of Black Church Social Services,” *Social Problems* 2, no. 52 (2004): 202-221.

²⁸ Seventh-day Adventist ministry is inclusive of administrators, chaplains, college and university religion professors, conference departmental directors, and pastors. While

community?

In my view, pastors who are trained in advanced care interventions may provide useful assistance before and after end-of-life encounters. However, pastors may have a lack of education that may lead to poor planning. Clergy need continuing education on dealing with the needs, issues, and concerns of the church and community. In an article entitled, "Marriage and Family Therapists and the Clergy: A Need for Clinical Collaboration, Training, Research," authors Andrew Weaver, Harold Koenig, and David Larson note, "Clergy who received education, training and support enhanced their knowledge and skills in counseling elders."²⁹ This article calls for clear terms of engagement through training and support. Is it possible that pastors are not providing better care to the aging population because they lack training in that area? Would training enhance the adoption of advanced care planning in the community or the church? These are questions that need to be tackled as the general population continues to age.

Among African-Americans, the "community" plays a vital role in the interplay and execution of both public and private initiatives. The adage, "It takes a village to raise a child," is conversely true when it comes to end-of-life care. Gwendolyn London and Robert Washington state, "Most African-Americans . . . travel the road from initial diagnosis to death with the support of a community of like-minded believers."³⁰ These

they may not all have frontline experience, in the life of the church, all the aforementioned persons are considered ministers.

²⁹ Andrew J. Weaver, Harold G. Koenig, and David B. Larson, "Marriage and Family Therapists and the Clergy: A Need for Clinical Collaboration, Training, Research," *Journal of Marital and Family Therapy* 23, no.1 (1997): 13-25.

³⁰ Gwendolyn London and Robert Washington, "Spiritual Care Near Life's End including Grief and Loss in the African American Community," in *Key Topics on End-of-Life Care for African Americans*, ed. Richard Payne (Durham, NC: Duke Institute on

“like-minded” believers may be people of the same cultural makeup or people at their places of work. For some people, church members are their community’s residents. The traditions of food, fellowship, and faith may allow grief-stricken people to express true feelings of sorrow, suffering, joy, and hope.

A survey conducted by the American Association of Retired Persons (AARP) reveals data related to African-American views on end-of-life care planning. The study reports that 83% of people stated it is very important to them to be at peace spiritually at death, but only 6% had spoken with a clergyperson about their end-of-life wishes; 79% of people did not want to be on life support, but only approximately half had an advanced directive; and 93% of people were aware of hospice, but only 24% knew Medicare pays for it.³¹ These statistics are staggering. What do these statistics say? I would submit that some of these statistics echo the Old Testament scripture that says, “My people are being destroyed for a lack of knowledge.”³² This cultural dynamic may be a result of a lack of access to knowledge.

Since the minister is viewed as a primary contact at the end of life, being a recipient of training may help the minister serve more families more fully. Experience and comfort play a significant role for African-Americans and healthcare decision-making. Important items such as hospice options and costs may not be known until the need arises. Others may choose not to participate in hospice or palliative care based on negative family or personal experiences with medicine and the medical community.

Care at the End of Life Initiative to Improve Palliative Care for African Americans, 2006, 66-78.

³¹ Gretchen Straw and Rachelle Cummins, *AARP North Carolina End of Life Care Survey* (Washington, DC: AARP Knowledge Management, 2003), 2-3, 16.

³² Hosea 4:6.

Spirituality plays a significant role in the African-American community. Worship services, ceremonies, and celebrations are vital experiences for African-Americans. Since spirituality plays such a vital role in African-American end-of-life care, clergy may be able to create a bridge of communication. Clergy may have not created a bridge for understanding because they did not have a thorough understanding of topics that encompass end-of-life care. One topic that arose in the study mentioned above is the need for advanced care planning. Advanced care planning involves everything from finances to end-of-life decision-making. Having an awareness of all options for parishioners facing terminal health challenges or needing elder care is important.

Advanced care planning in healthcare settings is vital for any minister to understand. There are two basic documents that all parishioners should be encouraged to fill out prior to their hospitalization or admission to a long-term care facility. These documents are the living will and the advanced healthcare directive. Living wills are used to assist families in making decisions that are critical should the need arise. Both documents give families options for medical care prior to a medical crisis. Living wills are documents that provide the patient's preferred treatment options and are shared with nursing staff. Medical teams view living will documents as binding unless the physician overrides them. Living wills may not be followed if a person codes and family members are not around to consent to cease life support.

Religious and Cultural Influences on Patient Care Needs

In addition to cultural dynamics, religious issues play a significant role in end-of life care. Verna Benner Carson and Harold G. Koenig discuss core spiritual issues that pastors need to be aware of as they engage in the caregiving process:

(i) the intense pain associated with grief, (ii) the need to know that there is a loving and sustaining God in the midst of the pain, (iii) the desire to emulate God's love, patience and faithfulness as the caregiving role is fulfilled, (iv) the need to have the answers to the ultimate question of why, (v) the need to feel connected to a greater and more powerful being who is able to make sense out of pain and death, (vi) the need for forgiveness when expectations and behaviors are incongruent.³³

Pastors who are exposed to and aware of the issues mentioned above may be better positioned to offer more competent support as needed. Without understanding the family and caregiver issues going on “in the moment,” misinterpretations of experiences may occur.

Understanding the role emotions play in caregiving is very important. The aforementioned spiritual concerns are factors that a person in ministry—chaplaincy, parish, or teaching—must be aware of. The thoughts and feelings outlined above offer insight into the thoughts, feelings, and emotions of caregivers. The feelings that Verna Carson and Harold Koenig collected are but a sample of the wide range of emotions that patients and family members experience in crisis. Knowing the information regarding the feelings that might be experienced may not alter the course of care for a family that is in need. Nonetheless, having an understanding of these sentiments may allow the minister to have an inside track on potential thoughts, feelings, and emotions.

Another factor in caregiving is the role of religion itself. So far, the positive sides of religion have been discussed. However, the role of clergy in caregiving may not always be helpful. Clergy also play a vital role that may be prohibiting or limiting the amount of care received. Could religion actually be harmful to health progress? Could

³³ Verna Benner Carson and Harold G. Koenig, *Spiritual Caregiving: Healthcare as a Ministry* (West Conshohocken, PA: Templeton Press, 2004), 139.

clergy be to blame? Medications and treatments may include use of products that are prohibited by diet.³⁴ Many Jews, Muslims, and Seventh-day Adventists adhere to a kosher style diet.

Many religions observe special customs that may filter into the healthcare setting. A patient's religious and emotional comfort should be at the height of concern for spiritual care providers. These concerns may seem minor but are really significant, such as the Jewish prohibition against pork products in all forms, even for altruistic surgeries, and Jehovah's Witnesses' hesitancy about the use of blood products for transfusions. Harold Koenig notes that patient care may be compromised as a result of a lapse in sensitivity to patients' religious beliefs.³⁵

Some patients' experiences in which religion conflicts with patient care may not require clergy intervention. On the other hand, some patients must rely on a bridge that may only be created by the patient's clergy. Koenig underscores the value of clergy as bridge builders who communicate with families in crisis. He explains that "situations may arise in which health providers' plans of care and patients' beliefs may conflict; at these times it is helpful to call a community clergy person who will provide clarity to health providers and patients about religious needs and concerns."³⁶

Religious leaders are used in many cases to translate the meaning, purpose, and validity of beliefs to staff and patients. In one instance, I had an Islamic family who requested an Imam for their dying relative. As their chaplain, I did not abandon them

³⁴ Carson and Koenig, *Spiritual Caregiving*, 134.

³⁵ Harold Koenig, *Spirituality in Patient Care: Why, How, When, What*, 3rd ed. (West Conshohocken, PA: Templeton Press, 2013), 142.

³⁶ Koenig, *Spirituality in Patient Care*, 143.

because our beliefs differed; I learned through the process. Initially, religious beliefs and patient care plans may conflict with each other. Out of the conflicting aims between healthcare providers and patients a conversation may become possible. This conversation may engender respect and trust and provide possibilities for further communication.

Clergy play a vital role in the conversation regarding advanced care planning. In particular, African-American clergy may significantly impact their parishioners' decision-making processes. Researchers for the National Alliance on Mental Illness (NAMI) published a manual entitled, *Working with Congregations to Reach African American Families with Mental Illness*. Their research indicates that "African Americans seek help from the clergy more frequently than from other professionals. . . . Unfortunately, often times faith leaders do not know about mental illness, how to help families dealing with mental illness, or they provide misguided recommendations."³⁷ Since clergy are frequently sought after in times of crisis, it would be prudent for ministers to learn more about the recommendations they are giving.

Resources for End-of-Life Conversations

Clergy play a vital role in facilitating end-of-life conversations. However, clergy may not be competent to hold those conversations without proper training or equipping. Although clergy competence may not be great, the influence of the church on the community may be high. The church can offer a series of conversations regarding end-of-life care planning. What would a conversation on end-of-life planning look like? How would it be conducted? What topics should be discussed or avoided?

³⁷ Majose Carrasco, ed., *Working with Congregations to Reach African American Families with Mental Illness* (Arlington, VA: NAMI Multicultural Action Center, 2005), 6.

Conversations regarding end-of-life care are multifaceted. End-of-life planning may include talk about advanced directives, life insurance, living wills, power of attorney, and funeral plans. The church may procure the services of professional social workers, nurses, and notaries public who would assist members of the church and or community. Hospital chaplains are vital resources who can provide training and equipping for pastors who are in need of this important information. The dialogue may take place at a time convenient for seniors and their potential caregivers. I feel that the environment would be more comfortable if the conversation were about more than just death. Having a conversation regarding “how to fulfill life’s meaning” may sound better than, “Come plan the way you want to die.”

The Conversation Project

End-of-life conversations are becoming a key need in today’s society. Within recent years, a movement has formed under the auspices of the Institute for Healthcare Improvement called, “The Conversation Project.” The Conversation Project is a grassroots public campaign to encourage people to make their end-of-life wishes known and to have them respected.³⁸ This conversation allows for families and caregivers to discuss their wishes, needs, hopes, and fears related to their healthcare and final days. The end-of-life planning conversation allows for people to collaborate for the purpose of providing consistent meaning to an individual or family. Having a sense of meaning at the end of life serves as a vital contributor to a “good death.” The Conversation Project website (www.theconversationproject.org) offers a wealth of resources for kids, pediatric

³⁸ C. Gunther-Murphy, Adams K. McCutcheon, and J. McCannon, “Is Your Organization ‘Conversation Ready?’” *Healthcare Executive* 28, no. 4 (2013): 62-65.

patients, and families. The website serves as an interactive portal for families not only to share their wishes, but to start their own end-of-life care plans. For churches and families looking to participate in this movement, this website would be a great resource for getting started.

Hospice

Hospices are another resource in the community. Many hospices offer end-of-life care planning options. They allow for patients and families to make meaning during end-of-life care situations. Hospice patients now may be discharged to hospice care while they are still inpatients in hospitals. Hospice options vary from city to city; some hospice care may be at home, while other care may be at hospice facilities. Regardless of the location, a goal of hospice is to provide care for patients and families until the patient dies. Many hospices also follow up with patients' families up to a year after their loved one's death.

Opportunities for Pastors and Ministry Leaders

What can pastors do to assist in providing care in end-of-life situations? Pastors can collaborate with those working in facilities to provide effective end-of-life care. Pastors and pastoral care providers have similar functions. According to William A. Clebsch and Charles R. Jaekle, there are four key functions of pastoral care: sustaining, guiding, healing, and reconciling.⁴⁰ These functions are ways to help people know they are valued and cherished people in the community. The functions are not cyclical but work together at different times for different purposes. The goal is holistic care and

⁴⁰ William A. Clebsch and Charles R. Jaekle, *Pastoral Care in Historical Perspective* (Northvale, NJ: Jason Aronson, 1975), 4, 8-9. The authors borrowed the first three from Seward Hiltner's *Preface to Pastoral Theology* (Nashville: Abingdon Press, 1958).

allowing a person to express his or her personality while being guided on a journey toward wholeness.

The pastor or minister also must be willing to confront parishioners in order to work toward reconciliation. Reconciliation may variously mean forgiving, apologizing, or accepting that the situation or a person's health status may not change. Although these principles may be utilized in end-of-life care scenarios, they are also useful for daily parish ministry.

Assessments

Assessments are a key to unlocking the emotional understandings of people. Spiritual assessments have at their core three key functions. Assessment through a series of questions allows a care provider to identify significant relationships, meaning, and purpose for a person and to apply that meaning to the person's current situation.⁴¹ The following spiritual assessment is one that I have found useful. I learned and developed this assessment as a result of a conversation with a fellow resident during my CPE residency and have adapted it to fit my needs. I use the acronym "SMC" for this assessment. The letters *SMC* stand for *spirituality, support, meaning, and coping*.

Spirituality

- Where are you in this?
- Where do you see God at work in this experience?

Support

- What support do you have?
- How has that support been for you?

⁴¹ D. W. Donovan, "Assessments," in *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*, ed. Stephen Roberts (Woodstock, VT: SkyLight Paths, 2012), 44-45.

- Do you have access to the resources needed to meet your present or long-term health challenges?

Meaning

- What is it like for you to lose your hair?
- What does it mean for you not to have the support of your family?
- What do you feel when you think of your loved one?

Coping

- What is helping you to cope today?
- Are you angry with God?

The beauty of spiritual assessments is that one does not have to be a trained professional psychologist to utilize them. Spiritual assessments are useful tools for end-of-life purposes. They are also wonderful inroads to the lives, personalities, thoughts, feelings, and emotions of other people. The assessment process may be challenging for some pastors because it requires confrontation. However, confrontation is a way for a person to speak the truth in love and to allow for a caring dialogue. Significant conversation may result from dialogue that requires a “carefronting” conversation.

Carefronting is conversation that is directed toward a person for that person’s well-being or to create a climate of mutual understanding in the midst of disagreement. Confronting others is documented in the New Testament; Matthew 18 outlines principles for dialoguing when there is tension between two parties. Spiritual assessments work in conjunction with confrontation to find the emotional value of the issue being discussed.

Utilizing effective skills and resources are paramount to offering care. Ministers in any role would do well to understand and implement meaningful ministry functions in context. Culture and traditions serve as key partners in effective care. Who is better

positioned to bridge cultural contexts than a minister who is embedded in the community?

Chapter Three

Personal Theology of Pastoral Care

End-of-life pastoral care requires calling, preparation, and reflection. The calling to a ministry of care is reflected in a person's concern for the welfare and well-being of others. Preparation for service to people at the end of life includes spiritual and academic preparation. Christian ministry focuses on the presence of God intervening and intersecting in the lives of caregivers and recipients.

There is a significant process that is included in the discernment of a ministerial vocational calling. Some people have been called from birth, like the Old Testament prophet Jeremiah. Others have had divine confrontational callings to ministry, like the New Testament's Saul who became Paul. Despite mode of calling, being a mouthpiece for God is significant.

Calling is what keeps a person traveling on a journey that involves seeing emaciated faces, tearful families, and bereaved loved ones. Discernment joins with calling to offer physical and emotional support. Ministers are called to be aware of God's movement in an encounter and to seek to join the Almighty at work.

A spiritual care provider may be called to do things he or she never thought possible. During the end of life, a person who has the honor of being in holy moments must be called to do so. End-of-life care takes on different facets—it may be crying one day and enjoying a party the next. A key factor for persons engaging in crisis or end-of-life care is discernment. Discernment is a sense, a voice, a feeling that prompts action.

Calling connects with discernment while engaging in spiritual care. Without knowing one is called, one could be trampling on someone's feelings without realizing it.

For a spiritual care provider to be effective, having a theological base is essential. P.O. Killen and J. De Beer state, "Theological reflection enables people to see their religious tradition as an even greater source of guidance by enhancing their own comprehension of its wisdom."⁴² As a result of my own theological reflection, my religious experience has become more meaningful. As a Seventh-day Adventist, my theology is based on the work of God from creation through to Calvary. My calling confirms that God's work in my life is to emulate the work of Jesus. Jesus said, "The Spirit of the Lord is on me, because he has anointed me to proclaim good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to set the oppressed free."⁴³ The power, authority, and influence that is used in the context of spiritual care is not for manipulation, but for emancipation from self and past experiences.

While I claim no divine power, I feel called to represent the presence of God to those I come in contact with. I feel I am a liberator, as the text from the gospel of Luke suggests. *I embrace the calling to be a presence in the midst of trouble.*⁴⁴ Being a presence does not mean I have all the answers, nor do I seek to solve problems. A presence is useful for whatever is needed in the moment.

⁴² P. O. Killen and J. De Beer, *The Art of Theological Reflection* (New York: Crossroad Publishing Company, 1995), viii.

⁴³ Luke 4:19.

⁴⁴ Psalm 46:1.

Theology is a broadly defined term about the study of God. There are many branches of the study of God that call for theological reflection. *Ecclesiology* is the study of the church. Although ecclesiology does not overtly claim theology as its apex, it does have at its foundation God. *Soteriology* is the study of salvation. Soteriology is inclusive of the engagement of God's action through salvation history to redeem humanity. *Eschatology* is the study of God in the last days. While the previous terms relate to God's interaction with humanity, they find their anchor in the study of theology. At its core, theology is a study of the relationship between the Creator and creation expressed through people.

The aforementioned theological terms are nuances or branches of the study of God in action. For Christians, the study of God is based on Christ's descent into the world and the wonder of his actions in the world. I Timothy 3:16 calls people to view God as high and holy, as witnesses to the "mystery of godliness." However, in the most practical sense, theology can also be seen as the intersecting point of God and humanity. From a pragmatic perspective, theology underscores the movement of God in the lives of people. How does God move? When does God move? These questions may assist theologians in their quest to discover the movements of God.

Theologians function as students of theology. Scholars write, research, and offer theories that may not involve practical application. Practical theology operates from a pragmatic stance. Public practical theology could be defined as "theology in practice." The goal of practical theology is to be able to bring concrete examples of God's action alive in everyday life. A portion of the challenge is learning to place God into everyday life. Churches are one prime example of this challenge. The *ekklesia* are called to live a

life before the world that testifies to the existence of God and the movement of God in daily life. There may be some core challenges to the church being the sole practical theology example. Although people are open to being used as a part of the example of *ekklesia*, the church does not engage with the broad intersection of theology and diversity of life. The church is limited to functioning within its biblical, denominational, and historical parameters. Several core functions of the church are described in Acts 2:42: “teaching, fellowship, eating and praying.” These functions are wonderful, but at the core is the work of ministering to people using a message or scriptural base that enables people to want to be a part of the *ekklesia*. In theory, the church should be a center of practical theology, but in practice, it is the center of apologetics.⁴⁵ In theory, the church may be a theological center. From a public practical theological understanding, the church functions as a harbor, while public practical theology functions as the ocean. While neither body of experience is negative, they are bound to operate under different guidelines and regulations.

I see practical theology as the critical engagement of “others” in a public arena. A definition of *others* would be people whose beliefs, languages, and cultural values are different from my own. A core question that may be asked by public practical theologians is, “What is going on (in me, in the room) with others?” In order to be

⁴⁵ Duane Bidwell, “Purposes of Practical Theology” (class lecture, Claremont School of Theology, Claremont, CA, January 28, 2014). Dr. Duane Bidwell noted that the three purposes of practical theology are (1) to discern appropriate responses and to reflect theologically and spiritually, (2) to revise ongoing practice of faith communities, and (3) to provide data for theological construction in order to transform practice and belief construction in human experience. Based on these criteria, the parish would not be considered the sole place for practical theology.

critically engaged with “others,” practical theologians must be grounded in their own beliefs. Practical theology has at its core practice or interaction with other people. This interaction occurs in many places and phases. From a Christian perspective, pastors, evangelists, and chaplains are all practical theologians. What makes them practical theologians? In my view, it is because the aforementioned persons study and engage the public while representing God on a continual basis.

While pastors and evangelists usually elucidate their religious perspectives, they may utilize the skills of public practical theologians to be effective. Pastors, evangelists, and teachers engage others from their hermeneutical lens based on their personal and denominational interpretations of the biblical text. A goal for pastors, evangelists, and teachers is to share beliefs in hopes of educating, winning, or discipling people. Chaplains utilize the same skills, being grounded in their own religious affiliation but not proselytizing.

Chaplains operate as a prime example of practical theologians. Chaplains are ministers who serve in an environment that differs from pastors’ contexts. Pastors are usually employed or endorsed by a denomination to serve local parishes. The training of chaplains is an extension of the theological educational process. Chaplains, on average, complete a 400-hour internship and a 1600-hour one-year residency program beyond a Master of Divinity degree and ordination.⁴⁶ To be board certified, the chaplain must complete another 2000 hours. In many religious contexts, pastors can be called to preach

⁴⁶ Although Clinical Pastoral Education (CPE) Centers fluctuate on some requirements, these were the requirements at my CPE center in Birmingham, Alabama. For more information on CPE requirements and other questions, go to <http://www.acpe.edu/StudentsFAQ.html>.

before graduating with a degree in religion or theology. After this, they are assigned to a parish to serve. Ministry in this capacity may be viewed as a “trial by fire.” Parish ministry offers few built-in resources for growth and development. Chaplaincy offers many continuing education opportunities, mentoring, action, and reflection while one is still engaged in ministerial practice.

Pastoral care is a multifaceted ministry. The goal of chaplaincy is to engage in a journey of presence and availability. Constantly, chaplains are faced with the challenge of being fully present to the religious needs of patients, staff, and possibly, an institution. Although the goal may seem simple, execution requires discernment and a consistent spiritual centering.

In a sense, chaplains are different from pastors in that they are tossed into a sea of religious diversity daily. Chaplains may be called to answer questions on topics ranging from religion to pop culture. When chaplains answer questions, they answer them from the worldview of their own religious identity. Often chaplains must balance between their own religious ideals and the needs of the moment. Reflection questions for chaplains may include the following: How do I manage my own theology in the face of religious diversity? During the visit, what is more critical—engagement with another’s religion or my respecting my religious beliefs? Should I follow my embedded theology or should I go with deliberative theology?

At the heart of their ministry, chaplains are theologically-biased religious pluralists. While being theologically biased may seem obtuse, it may be useful. Naomi Paget and Janet McCormack suggest, “Being a religious pluralist requires strength and wisdom for the chaplain who is faithful to his or her own faith and beliefs while being

respectful and supportive of people whose faith traditions and practices are different.”⁴⁷

I agree with Paget and McCormack’s notions of faithfulness to one’s own theological perspectives. It would be more challenging to foster deep relationships with others without a solid foundation. The part I really appreciate is the aspect of “respect.” Respect does not engender agreement. In my view, a healthy respect for another’s religious beliefs and values is the foundation for meaningful conversation. Without boundaries for oneself or respect for others, visits and interactions with others may not be fruitful.

Theological Motifs in Spiritual Care

End-of-life spiritual care may include overt and emerging theological motifs. The three motifs that are mentioned are included for their reciprocal value. These motifs are valuable to the care provider and to the one receiving the care. In some ways, these may be thoughts that are spoken or inferred during the end of life. Are you judging me? Do you understand my suffering? And finally, the question of eternity, where am I going? These questions do not make up the sum total, but they are present in the room. I recognize there are many facets of theology and pastoral care that could be discussed. I would like to limit the following theological discussion to the issues of judgment, salvation, and suffering in pastoral care at the end of life. These three motifs are central to my understanding of care because they confront me in my own practice of care.

Judgment, salvation, and suffering serve as a check-and-balance system. These ideas will be explored further in the following sections. Upon entering an end-of-life encounter I have to make sure that I am open to the experience, while being

⁴⁷ Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 15.

nonjudgmental. Next, I have to open myself to the suffering in the room. Finally, I have to be open to viewing salvation differently. I feel these motifs are essential to honesty and integrity in spiritual care.

Judgment

Theologically, judgments assume pronouncements from God on someone or something for some action taken. Paul was blinded for several days. Miriam suffered temporary leprosy. These judgments seemed to come from God for a time and then were taken away. In the context of pastoral care, judgments may result from presumptions based on appearance, lifestyle, or socioeconomic status.

A heart-centered approach to spiritual caregiving is a goal. The Old Testament records the words of the prophet to David's family, "Man looks on the outward appearance but God looks on the heart."⁴⁸ While it is impossible to do emotional x-rays for the motives and intents of people's hearts, it may be possible to miss opportunities for personal and professional growth and healing. Missed opportunities for effective care may be a result of an isolated worldview, prejudice, or privilege on the part of the caregiver. These lenses may cause judgment and fear to eclipse unconditional love.

I would submit that, in the context of spiritual care, it is not the patient's or family's hearts that need adjustment. It may be the caregiver's heart that needs adjusting. As a caregiver, a question must be, how do I see this person? Do I see them as a patient to chart? Do I perceive them as someone beneath me? Are they a person who has new prospects written all over them? What as a caregiver am I bringing to this experience?

⁴⁸ I Samuel 16:7.

What judgments or perceptions am I knowingly or unknowingly transferring to this person or group during this encounter? The New Testament provides an answer to judgment. Hebrews 9:27 establishes a boundary and a referee for all. The text asserts that all are appointed to die and then be judged by God. In essence, the judgment on lifestyle, socioeconomic status, or pedigree are not important, rather, they belong to God.

To assume the role of judge in a spiritual care encounter is to assume the role of God separated from the character of God. The role of a spiritual care provider is to be a representative of the character of the holy. The character of God is represented as compassionate, slow to anger, and abounding in love.⁵⁰ These attributes, like many other art forms, may be present in a caregiver but must also be cultivated to reach their full potential.

Salvation

Isaiah 33:22 gives a triune perspective of the salvific character of God. Isaiah calls the Lord, “a Judge, Lawgiver, and King.” What would these roles look like in the context of spiritual care? How are these three characteristics in concert or conflict? Building on the prior paragraph’s foundation, salvation in context begins as a work united with God. Psalm 24:1 declares, “The earth is the Lord’s and everything in it.” Since humankind resides on planet Earth, using David’s words, people must belong to God as well. Jesus describes his mission on Earth as seeking and saving those who are lost.⁵¹ In my view, God provides each person with an individualized path toward salvation, since God ultimately knows intimate details about each person, such as the number of hairs on

⁵⁰ Exodus 34:6, Psalm 103:8.

⁵¹ Luke 19:10.

his or her head.⁵² God must also know the issues, problems, and concerns I have been struggling with my entire life. I believe ultimate salvation will be consummated with the eternal reunion with Jesus in heaven. In the context of spirituality and spiritual care, salvation on Earth may look and feel different.

What is salvation? The *Holman Bible Dictionary* defines *salvation* as follows: “In its most basic sense, salvation is the saving of a life from death or harm. Scripture, particularly the New Testament, extends salvation to include deliverance from the penalty and power of sin.”⁵³ Two parallel questions arise from this definition: When do you start dying? And when do you begin living? What does salvation look like in the context of spiritual care?

E. Brooks Holifield describes salvation as “the experience of a power which delivers us from our weakness, ignorance and sin, and transforms us to a glorious freedom.”⁵⁴ Holifield’s description of salvation widens the scope of salvation to more than just forgiveness of sin. In my view, Holifield offers a passport of hope to those who experience salvation from this perspective. Salvation may look like forgiveness from a family member. Salvation may look like marital reconciliation. Salvation may be relief from suffering through death. Salvation may look like release from prison. Salvation ranges from discharge from a hospital to a diploma from a college. Too often, salvation is limited only to what can be seen and or perceived by the senses. Salvation also takes

⁵² Matthew 10:30.

⁵³ Trent C. Butler, ed., *Holman Bible Dictionary*, s.v. “Salvation,” (Nashville: Broadman and Holman, 1991), accessed October 2, 2014, <http://www.studydrive.org/dictionaries/hbd/view.cgi?n=5461>.

⁵⁴ E. Brooks Holifield, *A History of Pastoral Care in America: From Salvation to Self-Realization* (Eugene, OR: Wipf and Stock, 1983), 197.

on abstract qualities such as peace, hope, assurance, and rest.

Suffering

In the context of pastoral care, suffering offers a dualistic reality. It involves present suffering and future relief. Paul, a biblical writer, theologian, and missionary, underscores this concept. In Romans 8:18, Paul declares, “I consider that our present sufferings are not worth comparing with the glory that will be revealed in us.” Would it be fair to say that present sufferings are not worthy to be compared to future glory? Who is to say whose suffering is worse: a stage-four cancer patient or an elder with severe dementia who does not know his or her loved ones?

Many religious traditions have doctrinal teachings related to the afterlife. For many people holding onto life in the sunset years, the hope of heaven beams brighter daily. Heaven is seen as the eclipse and apex of life’s journey. Suffering and trial are completed for Christians once Jesus appears. In some ways, Christians have an austere affinity to suffering. Paul writes in Romans 5:3, 4, “Not only so, but we also glory in our sufferings, because we know that suffering produces perseverance; perseverance, character; and character, hope.” This text offers a badge of honor to those who suffer. While suffering may produce positive results eventually, it is not always enjoyable or appreciated in the midst of the struggle.

There are many Bible texts that offer some relief to those struggling under the burden of suffering. Revelation 21:4 is quoted for relief from inner suffering highlighted by an outer manifestations of tears. Suffering is comforted through the joy and hope of eternity. This is hope for a resurrection that will produce a reuniting of loved ones, an eternal view of the visage of God, and a departure from a sin-ravaged planet. While all

these lofty and attainable goals are helpful to those who are suffering, it may be difficult to hear heavenly sentiments while on earth.

While the New Testament offers a more futuristic approach to suffering, the Old Testament provides answers for present needs. In the midst of the chaos of suffering, people may ask, “Where is God in the midst of our suffering?” David the psalmist responds in Psalm 46:1 that God “is a very present help in trouble.” The psalmist’s words offer meaning and hope to anyone facing difficulty. Utilizing formal spiritual care language, David sees God providing a ministry of presence. This ministry of presence may come in different ways. God may be a bridge builder, a load sharer, a comforter, or an encourager. David opens the reader’s attention to God fulfilling the needs of those who are suffering.

Suffering may produce questions that may not have easy answers: Why did God allow my child to die? What will I do without my spouse? How can I move on with my life? To an outsider, these questions may not seem sensible or reasonable. In crisis situations where people have died, I have family members who say, “God knows best.” How does that statement help anyone? That statement removes the sufferer away from the pain, but could also distance the sufferer from God. In addition, that statement may evoke more questions than solutions.

It may be useful to suggest that a person direct their pain to their spiritual source of strength. Psalm 120:1 says, “I took my troubles to the LORD; I cried out to him, and he answered my prayer.” The role of the spiritual care provider may fluctuate based on the encounter. Spiritual care providers may be healers, prophets, teachers, or friends. All

these roles function in the context of relationship to point a person toward their source of divine strength and healing. While physical healing may not be possible in all situations, people can experience hope through the comfort of knowing they are not alone.

In conclusion, ministerial vocations are both sacred and meaningful. The practice of this vocation not only calls for personal transformation but also constant education and inspiration. Whether it is behind a pulpit or at a bedside, the goal is to provide meaningful ministry. The ministry provided should not only be meaningful to the receiver but also transformative to those who provide the ministry. While ministry functions may differ, theological reflection is a gift to ministers in all sectors.

Chapter Four

Data Analysis and Discussion

This chapter details the research methods used, the motives for, and the opportunities and obstacles encountered in this project. In order to study the communication disconnect between pastors, the medical community, and parishioners, a survey was conducted. The research data was collected through an online survey. The purpose of the survey was to ascertain the understandings of ministry leaders and their thoughts, ideas, and feelings related to end-of-life care. The research process included a pretest, a presentation, a post-test, and an evaluation of results.

Methodology

A mixed methods approach was used to help understand what thoughts, feelings, and practical value end-of-life care raised in ministerial practice. Primary concepts and foci of the survey included care before, during, and after a crisis. The survey's goals were (1) to assess the practical value of the information that was presented, (2) to evaluate ministers' end-of-life care understandings, and (3) to ascertain how ministers practice and execute care delivery. Each survey question that was used was chosen based on its assistance in answering the research question. The survey included questions related to the ministers' personal lives, ministerial practices, end-of-life care, and post-death care. For further information, the full questionnaire is included as Appendix B.

The research project was facilitated through the use of technology. The seminar was conducted via a webinar on Google Hangouts Over Air, and YouTube. After it was

conducted, it was immediately and automatically uploaded to YouTube.⁵⁶ Technology was also employed through the use of the online survey and data collection web platform called “Survey Monkey.”⁵⁷ Survey Monkey generated an Excel spreadsheet that aided data analysis and interpretation. An online survey method was chosen because of its practical use and the lack of bias from the researcher or other participants. In other words, research participants were able to answer questions without coercion from the presenter or other participants.

Participants

The survey was conducted with ministry leaders in the Seventh-day Adventist church. While pastors were the primary focus for the research conducted, I included other ministry leaders. Ministry in the Seventh-day Adventist church is multifaceted. Ministry positions include being an administrator, a chaplain, a college or university professor, a departmental director, or a pastor. The terms pastor and minister are interchangeable according to ministry assignment and function.⁵⁸ I thought the scope and breadth of the research (pretest, webinar, and post-test) may significantly impact ministry practice in general.

All the aforementioned positions are not parish ministry front-line positions. The persons chosen for the survey may influence better practices of ministry in the parish through their private, personal, public, and policy influences. The previously mentioned

⁵⁶ Juleun A. Johnson, “Pastors As Caring Bridge Builders in Healthcare Settings,” YouTube, Oct. 19, 2014, <https://www.youtube.com/watch?v=umGrb8HHHO0>.

⁵⁷ Juleun A. Johnson, “Pastors As Caring Bridge Builders in Healthcare Settings Post Test,” Survey Monkey, <https://www.surveymonkey.com/s/XSWRQXB>.

⁵⁸ General Conference of Seventh-day Adventists Secretariat. *Seventh-day Adventist Church Manual 18th ed.* (Hagerstown, MD: Review and Herald, 2010), 21.

persons serve people who may be affected by end-of-life and or crisis-care scenarios.

The persons they serve may be fellow ministers, ministers' families, staff, or students.

Participants for the research project were recruited through the use of technology. *Facebook* was used as the method to solicit participants. I sent a *Facebook* message via two different Seventh-day Adventist pastors' forums. These forums represented age, ethnic, and occupational diversity. My introductory email included all the necessary items to participate in the research: the informed consent form, a welcome letter, links to the pretest and post-test, and the presentation. Vital information for the project is included in Appendices A, B, and C. The email also included a one-hour timeline commitment for the participants. The estimated hour included 10-15 minutes for the pretest and post-test and 30 minutes for the presentation.

Data

More participants completed the pretest than the entire survey. Thirty people completed the online pretest survey, but only twelve of those (40%) participated in the post-test and submitted informed consent forms. Since there was an uneven number of participants who did the pretest versus the post-test, it needed to be determined which participants did both tests. This determination of which surveys to use was made based on receipt of the signed informed consent form. Demographic questions included gender, ethnicity, educational degree, years in full-time ministry, full-time ministry function, and current ministry setting. The demographics of the survey are shared in Table 1.

Table 1

Question	Responses	Number
Q1. Gender	Female	3
	Male	9
Q2. Ethnicity	African American	8
	Asian/Pacific Islander	1
	Caucasian	1
	Hispanic	2
Q3. Highest Educational Level	Bachelor's	1
	Doctoral	2
	Master's	9
Q4. Years in Full-Time Seventh-day Adventist Ministry ⁵⁹	0-5	5
	6-10	3
	11-15	
	16-20	1
	21-30	2
	30 and above	1
Q5. Full-Time Ministry Function ⁶⁰	Chaplain	8
	Departmental Director	1
	Pastor	3
Q6. Current Ministry Setting	Suburban	1
	Urban	11

The questionnaire provided an opportunity for participants to demonstrate their learning of the seminar material. The forms of responding to the questions in the pretest and post-test ranged from a scale format, multiple choice options, true or false, and a comments section. The following research questions were used in the survey and provided meaningful data in the research process:

Q7. When a crisis arises in your ministry, do you feel equipped to provide a ministry assessment?

Q8. How often will you hold seminars in your ministry context regarding grief

⁵⁹ Not all the respondents answered this question. Answers given in the table reflect the answers given during the survey.

⁶⁰ Although college and university professors are mentioned in the survey, they did not participate in it.

recovery?

Q9. Kubler Ross's 5 stages of dying are an effective tool for assisting surviving relatives in grief recovery.

Q10. When someone dies in your ministry context, do you have a debriefing session with the surviving relatives?

Q11. How often will you communicate to those you serve about advanced healthcare directives?

Q12. Having your own advanced directive aids you in giving guidance about advanced care planning.

Q13. Having an awareness of more than one healthcare intervention assists you in helping those you serve in crisis.

Q14. There is a distinct difference between hospice care and palliative care.

Q15. Ministry of presence at the end of life is . . . ?

Q16. Being a pastoral bridge builder in a healthcare setting means . . .

Q17. What has been the strongest trigger of grief in those you serve lately?

Q18. During a crisis are you likely to . . . ?

Q19. When someone you serve dies, do you . . . ?

Below, each question is summarized and conclusions are given based on the research conducted. Following the questions, a table summarizes participants' responses.

Question 7 asked if the minister felt equipped to provide a ministry assessment when a crisis arises. In the pretest, no respondent felt prepared every time, 5 respondents felt prepared often, 6 respondents felt prepared sometimes, and one felt prepared rarely. However, after the 30-minute seminar, 9 of the 12 respondents felt more equipped.

In most of the respondents, there was an upward movement of a better sense of preparedness in providing a ministry assessment when a crisis arises. This may mean that survey participants were positively impacted by the need for spiritual assessment. While the data suggests that a person may have been aware of assessments in the past, they may choose to implement suggestions given in the presentation about doing assessments. The table suggests that survey participants may feel more confident in providing and implementing ministry assessments in their day-to-day functions after the

seminar. The table below illustrates the comparison between pretest and post-test responses.

Table 2

Q7. When a crisis arises in your ministry do you feel equipped to provide a ministry assessment?

Answer	Pretest												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Every time													
Often	x			x			x			x		x	5
Sometimes		x	x		x	x		x			x		6
Rarely									x				1
Never													

Answer	Post-Test												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Every time				x			x				x		3
Often		x	x			x			x				4
Sometimes	x				x			x		x		x	5
Rarely													
Never													

Question 8 asked a direct question related to ministry practice. To the question of how often the ministers would hold seminars in their ministry contexts regarding grief recovery, there was a movement in two directions. After the 30-minute presentation, 3 respondents chose to give grief seminars more often, 3 of them less often, and 6 had the same answer. This may suggest that after the presentation, the ministers may not have felt competent or comfortable leading a grief seminar. The survey trend also intimates that while ministers were concerned about grief recovery, it may not be happening as much as they would like. Table 3 illustrates how ministers were impacted to host or offer

grief recovery seminars after participating in the survey.

Table 3

Q8. How often will you hold seminars in your ministry context regarding grief recovery?

Answer	Pretest												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Once a Year			x		x						x	x	4
Twice a Year				x					x	x			3
Once a Quarter													
Monthly								x					1
Never	x	x				x	x						4

Answer	Post-Test												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Once a Year			x		x								2
Twice a Year						x			x		x		3
Quarterly								x				x	2
Monthly													
Never	x	x		x			x			x			5

Question 9 had the purpose of finding out if the respondents were acquainted with Kubler Ross's 5 stages of dying. This question stated, "Kubler Ross's 5 stages of dying are an effective tool for assisting surviving relatives in grief recovery." The respondents could answer "true," "false," or "I don't know." In the pretest, 6 of the respondents answered "true," 1 answered "false," and 5 answered "I don't know." However, in the post-test, 11 of the respondents answered "true." Almost all of the respondents seemed to have a better understanding of Kubler Ross's 5 stages of dying after the 30-minute presentation.

This shift may be indicative of several important factors. The persons surveyed may have seen that understanding and sharing the five stages of dying with others may

make grief appear survivable. Another point of consideration may be that ministers were aware of the five stages of dying but just did not know their official name. Another factor may be that the ministers may think that knowing and applying the five stages of dying during grief may not be useful. Table 4 illustrates the thoughts of participants.

Table 4

Q9. Kubler Ross's 5 stages of dying are an effective tool for assisting surviving relatives in grief recovery.

Answer	Pretest												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
TRUE	x		x	x		x			x		x		6
FALSE										x			1
I don't know		x			x		x	x				x	5

Answer	Post-Test												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
TRUE	x	x	x	x	x	x	x	x	x		x	x	11
FALSE										x			1
I don't know													

Question 10 asked about debriefing sessions following a death. It was designed to discover the frequency of sessions in relation to deaths. On the post-test, 4 of the respondents perceived themselves as having debriefing sessions with surviving relatives more often than they did on the pretest, and 4 of the respondents perceived themselves as having debriefing sessions less often. Based on the information presented, ministers may have come to think they were not doing debriefing sessions but were instead facilitating a ministry of presence at the time of death. Table 5 illustrates participants' choices.

Table 5

Q10. When someone dies in your ministry context, do you have a debriefing session with the surviving relatives?

Answer	Pretest												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
Every time	x						x				x		3
Often				x					x	x		x	4
Sometimes		x			X	X							3
Rarely			x					x					2
Never													

Answer	Post-Test												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
Every time				x								x	2
Often	x					x	x				x		4
Sometimes		x	x						x				3
Rarely								x					1
Never										x			1

Question 11 ascertains the frequency of the pastor's communication with members about advanced care directives. For those who were not pastors, their communication would apply to those in their specific service line. A goal of this question was to assess if the pastors' consistent communication with their members would help the members understand advanced directives. On the post-test, 4 of the respondents decided to give seminars more often, 3 decided to give them less often, and 5 answered the same frequency. This may signify that research participants understood after the presentation how meaningful advanced directives may be. Another conclusion is that a need may have been discovered to have the conversation regarding advanced directives more frequently in ministerial practice. Table 6 depicts participants' responses.

Table 6

Q11. How often will you communicate to those you serve about advanced healthcare directives?

Answer	Pretest												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Once a Year					x		x				x	x	4
Twice a Year									x				1
Once a Quarter													
Monthly				x		x		x		x			4
Never	x	x	x										3

Answer	Post-Test												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Once a Year			x	x								x	3
Twice a Year								x	x	x	x		4
Quarterly					x								1
Monthly						x	x						2
Never	x	x											1

Question 12 is related to the pastors' personal lives. Pastors who have completed their own advanced directives may be better positioned to give counsel and guidance to church members. Some of those surveyed may not feel comfortable giving guidance about advanced directives because they do not have any for themselves. On the post-test, all of the respondents agreed that having their own advanced directives aids in giving guidance about advanced care planning to other people. Table 7 shares participants' thoughts.

Table 7

Q12. Having your own advanced directive aids you in giving guidance about advanced care planning.

Answer	Pretest												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
TRUE	x	x	*	x		x	x	x	x	x	x	x	12
FALSE					x								

Answer	Post-Test												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
TRUE	x	x	x	x	x	x	x	x	x	x	x	x	12
FALSE													

* This question was not answered during the pretest by the participant.

Question 13 addressed ministers' awareness of interventions while serving in a hospital setting. The data indicated that everyone agreed on the benefit of knowing about different health care interventions, both before and after the presentation. With an awareness of more than one healthcare intervention, pastors may serve as more than a spiritual presence. The pastor may be able to transition to being a health advocate for their parishioners as appropriate. While pastors may not be able to make decisions for members, knowing the options may lead to better clinical outcomes. I see the pastor fulfilling this role by simply saying, "I know you had intervention X; have you thought about intervention Y?" Table 8 shares the thoughts of participants regarding healthcare intervention knowledge.

Table 8

Q13 Having an awareness of more than one healthcare intervention assists in helping those you serve in crisis?

Answer	Pretest												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
TRUE	x	x	x	x	x	x	x	x	x	x	x	x	12
FALSE													

Answer	Post-Test												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
TRUE	x	x	x	x	x	x	x	x	x	x	x	x	12
FALSE													

The responses to Question 14 may indicate further understanding in distinguishing end-of-life care options. Although the care options are similar, they offer different benefits and treatment plans. More respondents had a more accurate understanding of the difference between hospice and palliative care after the 30-minute presentation than before it. On the pretest, 9 of the respondents showed they knew the difference between hospice and palliative care, while on the post-test, 11 of the respondents indicated they knew the difference. This may allude to the fact that participants may have been aware of the topics discussed, but they were influenced to learn further about the distinctions between the two forms of care. Table 9 gives participants' responses concerning the distinction between hospice and palliative care.

Table 9

Q14. There is a distinct difference between hospice care and palliative care.

Answer	Pretest												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
TRUE	x	x		x	x	x	x		x	x	x	x	9
FALSE												x	1
I don't know			x					x					2

Answer	Post-Test												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
TRUE	x	x	x	x	x	x	x	x	x		x	x	11
FALSE													
I don't know										x			1

Question 15 highlighted several options for understanding what a ministry of presence looks like at the end of life. The options included the following: communication with the family, prayer after the death, being with the family as a presence, silence, and assisting in funeral arrangements. Initial results indicated that 8 participants preferred a ministry of presence, and 4 indicated that silence was their preferred option for end-of-life care. However, on the post-test, 10 participants chose being with the family as their ministry of presence. This growth shows that participants may have been aware of the care option before, but may have learned to utilize a ministry of presence more effectively through the presentation. Table 10 shares participants' responses to what a ministry of presence at the end of life should be.

Table 10

Q15. Ministry of presence at the end of life is . . .

Answer	Pretest												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Communicating with family members													
Praying over the parishioner after death													
Being with the family		x		x	x	x	x		x		x	x	8
Silence	x		x					x		x			4
Assisting in funeral arrangements													

Answer	Post-Test												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Communicating with family members													
Praying over the parishioner after death													
Being with the family		x	x	x	x	x	x		x	x	x	x	10
Silence	x							x					2
Assisting in funeral arrangements													

Question 16 offered participants the option of choosing what being a pastoral bridge builder in healthcare settings meant to them. The data suggests that there was minimal change in the perception of their roles as pastoral bridge builders. The presentation may have confirmed the thoughts participants had prior to the test. Table 11 suggests that pastors may see their role as being a presence during a tumultuous time for a family.

Table 11

Q16. Being a pastoral bridge builder in healthcare settings means . . .

Answer	Pretest												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
Communicating with family members regarding the health diagnosis				x									1
Talking to the medical team on the family's behalf					x			x					2
Supporting the family through a ministry of presence	x	x				x			x	x	x	x	7
Networking on the hospital unit for the benefit of the family			x				x						2

Answer	Post-Test												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
Communicating with family members regarding the health diagnosis					x	x							2
Talking to the medical team on the family's behalf											x		1
Supporting the family through a ministry of presence	x	x	x				x		x	x		x	7
Networking on the hospital unit for the benefit of the family				x				x					2

Question 17 inquires about the participants' ministerial practices. Options for answers to this question included birth, death, divorce, or loss of income. It was expected for the pretest and post-test to be about the same, since the question asks about the "strongest trigger of grief in those you serve lately." The results do show that death (health-related in many cases) is the greatest trigger of grief for church members. Table

12 shares the most significant triggers of grief survey participants observed in their practices of ministry.

Table 12

Q17. What has been the strongest trigger of grief in those you serve lately?

Answer	Pretest												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Birth													
Death	x	x	x	x		x	x		x	x		x	9
Divorce					x			x					2
Loss of Income											x		1

Answer	Post-Test												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
Birth													
Death	x	x		x	x	x	x		x	x	x		9
Divorce			x					x					2
Loss of Income												x	1

Question 18 asked, “During a crisis are you likely to . . .?” The four possible answers were “hide your emotions,” “act in a supportive role,” “be a friend,” and “distance yourself from the family.” Most respondents (11 on the pretest and 10 on the post-test) chose “act in a supportive role.” The only other answer selected on the pretest and post-test was “be a friend.” There was no significant difference in answers given. However, the ministers’ willingness to be emotionally engaged by “acting in a supporting way” and “being a friend” to the people they serve is significant. Table 13 illustrates these results.

Table 13

Q18. During a crisis are you likely to . . .

Answer	Pretest												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
hide your emotions													
act in a supportive role	x	x	x	x		x	x	x	x	x	x	x	11
be a friend					x								1
distance yourself from the family													

Answer	Post-Test												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
hide your emotions													
act in a supportive role	x	x		x	x	x		x	x	x	x	x	10
be a friend			x				x						2
distance yourself from the family													

Question 19 ascertained what pastors do following a death among the people they serve. No significant difference in answers was expected on the post-test, since the ministers knew what they normally did. However, it is worth noting that most of the respondents (8 on the pretest and 7 on the post-test) follow up with the surviving family members monthly. The methods of follow-up with surviving relatives are not known. What is apparent is that follow-up was indicated as a meaningful practice on both the pretest and post-test. Those who said they did no follow-up may not have the time to do so. Table 14 illustrates the responses to Question 19.

Table 14

Q19. When someone you serve dies, do you . . .

Answer	Pretest												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
honor their memory annually									x				1
check on their surviving loved ones monthly	x				x	x	x	x		x	x	X	8
do no follow up with their family			x										1
pray for them periodically with no contact or voice or person-to-person contact		x		x									2

Answer	Post-Test												Total
	1	2	3	4	5	6	7	8	9	10	11	12	
honor their memory annually						x			x				2
check on their surviving loved ones monthly	x		x	x			x	x			x	X	7
do no follow up with their family					x					x			2
pray for them periodically with no contact or voice or person-to-person contact		x											1

Pretest Open-Ended Responses to Question 20

Question 20 was an open-ended invitation for feedback. The previous questions had been closed-ended, meaning answers were limited to specific choices. Question 20 afforded the participants an opportunity to share thoughts, values, opinions, and judgments regarding the survey. Comments were requested regarding the awareness and thoughts of participants. The responses are not in order of priority. Numbers are given to differentiate the responses. On the pretest, 3 of the 12 participants, or 25% of respondents, replied to Question 20. This may have been because they wanted to share their initial thoughts prior to the presentation. These comments share the reflective

journey between the participants and the survey questions prior to participating in the webinar presentation. Question 20 stated, “Please share the benefits and or usefulness of the information during this presentation to your ministry and context in the space below.”

The comments were as follows:

1. Good idea factory
2. A good self-check and reminder of priorities when giving support to those who are grieving.
3. Good reminders

As one can see, two of these responses were very short answers and the third was a brief phrase. The comments may have indicated a learning or awareness of concepts prior to the project. Two of the answers began with the word *good*. Two of the responses indicate that the survey provided useful hints and reminders of effective spiritual care practice.

It seems the pretest stirred up a sense of the potential of the concepts to be presented. The longest comment suggested that the survey questions opened the participant’s mind to effective ways to be supportive. This comment shows that the participant, while not knowing the contents of the presentation, may see the need for further study on spiritual care principles and practices.

Post-Test Open-Ended Responses to Question 20

Many of the participants commented following the presentation. On the post-test, 10 of the 12 participants responded to Question 20, representing 83% participation. This is compared to the pretest’s 3 responses, or 25% participation. There is a shift in the length of responses from the pretest to the post-test. The range of responses is from short notes to expansive comments. These comments reflect the participants’ thoughts after

viewing the webinar presentation. The responses are shared verbatim as collected from the survey:

1. I appreciated all of the presentation there was clear communication of the different aspects of supporting families that can be helpful for us to know as clergy. I especially liked the sample questions that we can ask patients or families when trying to support them.
2. It allowed me to realize how limited is our training in the area of pastoral support in situations of crisis with our church members. It also helped me re-discover the benefits of the Pastoral Care training we receive in the CPE program.
3. The survey was difficult to answer because I often wanted to choose more than one option. In the presentation, I appreciated the section on assessments (SMC), ministry of presence, and ways to support surviving relatives after a death. I am going to try to be more intentional to use SMC in my visits. Also, I would like to find a viable bereavement process to remember deceased patients and/or check in with surviving relatives. Though I am a chaplain, I learned some new info and I think this presentation would be extremely beneficial for pastors in a church setting. I do wish there had been mention of a significant difference between hospice and palliative care... Palliative care is not only for those facing EOL, but is also supportive care for those with chronic diseases (COPD, CHF), complex situations, difficult family dynamics, who may recover, or may not be in a terminal condition yet. Patients must meet specific criteria for hospice care, and usually they have 6 months or less to live. Thank you for a very comprehensive and thoughtful presentation.
4. The presentation was very helpful. It was good reminder of things that I do as a Chaplain and gave me idea of things that our Pastoral Care Department could do in the future to help those with grief. Thanks.
5. Excellent presentation
6. Well put together
7. It was extremely useful as I was able to clearly see how I can apply what was covered in my current ministry practice.
8. I love the approach of "I've come to be with you." Some fine questions of assessment I can use, such as "What is this like for you?" and the questions of Spirituality and Support, Meaning, and Coping. Good stuff, Juleun.
9. I really appreciated several reminders of the importance of the pastoral competency with families in grief. Several guiding points stood out to me. One the most powerful point for me was the presence of the pastor. It reminds me that I am a representative on God's behalf. While He is actively working all things out for our good, much of that support and active advocacy He does in silence. In addition, I appreciated the assessment questions, reminding us that when we speak we are to be inquiring and permitting the client to take us on the journey with them, rather than thinking that we know the way in which to lead them somewhere. Finally this is not so much related to what I have

learned but rather how I felt about the overall presentation, I found it to be informative and interesting. So many presentations might be informative but they lose my attention part way through. This may not be the fault of the presenter, maybe its just me. But with your presentation I found myself eager to hear more. I really enjoyed the few personal examples within your own experience. Thanks for inviting me to be a part of your learning experience, and equipping me in my ministry.

10. Comments from the YouTube page: Really appreciated the affirmation of the pastors presence. I must admit when I get into such a setting the temptation is to find the right thing to say. As if I can make it all better? I will be much more comfortable sitting in silence now. I imagine this webinar will be an anchoring reminder. I also appreciated the emphasis on assessments. Is there a book that provides more questions of the SMC approach?

Post-Test Comment Suggestions

Comments from the post-test suggest that participants appreciated the research in the presentation. The comments indicate the webinar had significant personal and professional impact. The reflections of participants may indicate their ministry focus was widened. Participants' post-test comments suggest they are interested in learning more. Compared to the pretest, post-test comments were longer and included more personal reflection.

Post-test comments indicate that the seminar aided people in their ministry practice. Comments also stated that their energy for ministry was reignited. One participant stated he or she "rediscovered the benefit of pastoral care training," as a result of the seminar. Another person shared that the seminar provided a much needed bridge over an educational gap to those in need.

Many people appreciated the practical takeaways the seminar offered. A part of the seminar that participants voiced particular appreciation for was the assessment given in the seminar. They indicated that it had great practical value. The idea of a ministry of presence may have been new for some people, while others found it a refreshing

reminder. Participants were challenged and confronted with new information and how to use it.

The seminar provided theoretical and practical value. In addition to the intellectual knowledge gained during the seminar, the presentation seemed to affect the participants' pastoral functioning. One participant noted that being silent may assist them because they will not have to try to come up with the right words to say, but it also is a growing edge for them. Another person shared that the ministry of presence was meaningful for them. Following the seminar, once hesitant ministers now seemed to be open to journeying with patients and families through their experiences. This may indicate that ministers may not only be anxious during visits but uncomfortable. In addition to personal value, the seminar seemed to have potential significant impact on chaplaincy practices. One chaplain said that this presentation may assist a pastoral care department in becoming more effective in care delivery.

The seminar highlighted care throughout the end-of-life care process. The evidence of the impact of the seminar is realized in the comments on the post-test. While many comments noted the practical value the seminar held, some results of the seminar may never be known by me. One participant stated that they appreciated the attention to following up with family members. The seminar seemed to start a wave of thinking about post-death care. A participant shared that he or she would like to think of other creative ways to connect with surviving relatives.

The seminar seemed to support my thesis that pastors may need further education in the area of end-of-life care. This research suggests education could be the first step in improving ministers' end-of-life care practices. One person indicated they wanted to

engage in further study by asking for resources related to pastoral care and end-of-life care principles.

The majority of the comments on the presentation were positive. However, one participant highlighted a need that the presentation overlooked. This participant shared that, while the majority of the presentation was clear, the hospice versus palliative care difference should have been expounded on more. The comment represents a growing edge in an area of hospice versus palliative care.

One area that was emphasized in the seminar and was overlooked in the comments section was the need for personal advanced directives. Comments were aligned with the need for training, education, and implementation, but in terms of personal application, there were no comments. It may be possible that some principles mentioned in the presentation may not receive full endorsement until care providers participate in them. An example of this idea is that pastors may not encourage members to participate in advanced care planning because they have no plans for themselves. The lack of personal advanced care plans may be reflected in the fact that the comments section does not have any comments about this topic.

Those who watched the presentation stated they could see both the practical and theoretical benefits of the presentation. Many comments came from the chaplains who participated. Chaplains stated that they would implement the material into their context of ministry immediately. One chaplain said that the presentation was not only meaningful for him or her as a chaplain, but it would be invaluable to parish pastors. Other participants stated that the assessments were helpful in moving them toward more meaningful conversations.

My research provides and opens the window to a need for more equipping of pastors in end-of-life care ministry. In addition to training, research participants seem to be open to other ways of caring for those in their contexts. Further discussion of the potential effectiveness, limits, and consequences of the seminar will be highlighted in Chapter Five.

Chapter Five

Summary and Conclusions

This project serves as a foundational beginning point for the process of understanding end-of-life care from pastoral perspectives. A goal of this project was to view and assess the needs of pastors serving families who are facing end-of-life challenges. The project that has been undertaken serves as a preliminary (or pilot) study toward a more comprehensive educational response. The project was open to Seventh-day Adventist ministers, and the majority of respondents were African American.

Participant responses highlighted many significant needs. A primary need that participants indicated was the need for more end-of-life care training. Following graduation from seminary, Seventh-day Adventist parish pastors are not required to attend any more classes to maintain ordination status. The only Seventh-day Adventist ministers that must complete continuing education hours are those in specialized chaplaincy training. Participants stated that they would like to know of resources and have information that may assist them in serving those in end-of-life situations.

Another factor that was underscored through the project was that pastors care about those they are serving. This project highlights that pastors are not only hardworking but are interested in the well-being of those they serve. Many dedicated ministers may not get tangible thanks following the death of a parishioner. I would submit that the gratification experienced by pastors is not about money, but about seeing those they serve having access to resources to meet end-of-life care needs.

Conclusions Drawn from the Project

There are several conclusions that may be drawn from this research project. First, ministers in parish and specialized settings are seeking meaningful continuing education opportunities. What opportunities are there available for Seventh-day Adventist ministers? For nearly 35 years, the Seventh-day Adventist Regional Conferences has offered a conference called “Pastoral Evangelism Leadership Council (PELC).” This annual conference is held on the campus of Oakwood University in Huntsville, Alabama. The convocation serves as a training catalyst for African-American Seventh-day Adventist pastors. PELC is designed to offer seminar tracks for pastors to assist in enhancing parish ministry. While the seminar tracks are important, they are not connected to any educational program. What may be of benefit is to include assignments as part of the seminar tracks and to then link the years of PELC tracks to degree credit. These tracks could include some end-of-life training.

I observed during this project that many pastoral colleagues have a strong desire to improve care for self and others. Many participants’ comments indicated they appreciated the practical tools they received. Participants seemed highly motivated to learn more, which was highlighted by the request for additional resources to assist in care delivery.

This project helped me to realize that effective ministry may be happening by accident, without deliberate training. However, people may also be missing out on community resources that are available, regardless of the size of the city in which they reside. This project serves to underscore the importance of intentional ministry as it relates to moving pastoral conversations toward an experiential journey together.

The project also highlighted the lack of ministers' understanding of the medical community. While ministers may receive a theological education, they may also need to learn the terminology and structure of healthcare. This knowledge deficit may be a result of a lack of exposure to healthcare resources. Even ministers whose service is not focused on the elderly population need to develop competency in understanding healthcare documents such as advanced directives and living wills. For effective care to transpire, ministers may need to develop a working knowledge of end-of-life care terms such as *advanced directive*, *living will*, *quality of life*, *hospice*, and *palliative care*.

Another strong implication of my research is that ministers need to become true citizens of their communities by accessing appropriate resources. Both small and large communities have considerable resources that may not be known by the people in those communities. The pastor may serve as a quarterback directing families in accessing necessary resources. Ministry in specialized or parish settings must no longer be done in denominational isolation. Pastors must be willing to be active and engaged participants of the communities in which they live and serve.

Ministry Implications

One of the main ministry implications is that some ministers operate as if they have knowledge they do not actually possess regarding end-of-life care. Hosea 4:6 says, "People are being destroyed for a lack of knowledge." The current lack of knowledge may include a lack of information regarding resources. This deficiency is not only detrimental to parishioners but also to the minister. If the minister does not have information, they are not able to disseminate knowledge, resources, or information to those who need it most. Core qualities needed in ministers to acquire knowledge are

humility and a willingness to learn. Information regarding end-of-life care can be gained through many avenues, including seminars, classes, and mentoring.

In our current society, people are dying at an alarming rate. The statistics from the AARP show that church members rely on ministers' guidance more than the medical community at times near death. While this may be true, it also highlights the broad gap in the community. This finding emphasizes how critical it is for parishioners to experience the presence of God near death. Since the presence of God is important, having an equipped facilitator may not only assist others in their end-of-life journeys, it may act as consolation for surviving relatives.

Another theological implication of the AARP's finding is that ministers may not only represent the presence of God but also the religion itself to people in need. As shared in Chapter Two, Harold Koenig suggests that pastors may be translators of religious meaning and ritual to the medical community. This act of translation may not only bring comfort to a family but also to the medical staff—nurses, doctors, and pharmacists—on the patient's unit.

This project highlights the need for pastors and other spiritual leaders to develop a philosophy of the ministry of presence. In the midst of end-of-life and other crisis care scenarios, pastors must be a "very present help in the midst of trouble."⁶¹ Chapter Three highlighted three theological motifs where a presence ministry is needed. This presence includes being non-anxious, nonjudgmental, and open to binding the wounds of the hurting.

A final ministry implication involves the challenges incurred by a lack of

⁶¹ Psalm 46:1.

education. Everyone suffers when clergy are not properly educated regarding the virtues of end-of-life care. Potential donors to parish ministry are lost when surviving relatives are not honored. Potential converts and potential conversations are missed. Communities suffer and taxpayers sustain the weight of the lack of end-of-life care planning.

Educational Goals

One of the goals of the project was to make the project practical to every participant in the study. A gentle balancing act was done. This project included people from four different aspects of Seventh-day Adventist ministry: administrators, chaplains, departmental directors, and pastors. Each of these ministry personalities interacts with people who are facing end-of-life challenges as caregivers or for themselves.

I feel that the tools presented in my webinar were a beginning. This project does not assume that this is the only information beneficial to ministry at the end of life. Resources described in the project are available in both small and large contexts and in rural and urban environments. Beyond this work, each city, county, and hospital have a wealth of resources to aid ministers in their quest to offer effective end-of-life care.

Seminar Evaluation

The seminar seemed to be effective in underscoring the thesis of this project. The research implies that pastors may not have received training in end-of-life care. The survey results and the comments suggest that the participants are willing to expand their ministry practices and philosophies. Participants in the seminar were open to having an alternate view of doing ministry.

The seminar had a dual intention. Primarily, the seminar was designed to expose

pastors to end-of-life needs and principles. The secondary purpose was to give pastors practical tools that could be implemented with church members now. The assessment and community resources mentioned in Chapter Two are practical elements that participants may include in their ministries in the present.

The seminar seemed to have significantly impacted the ministers who participated. Comments indicated the awakening of consciousness in caregivers who are professionals. I do wonder what the impact of the seminar would be on those who have not received theological training or education.

Based on the data, the pastors appeared to understand their personal limits in providing end-of-life guidance. The results of my research suggest that pastors may not be able to give seminars on their own. Chapter Four described several reasons why pastors may not feel comfortable giving seminars regarding end-of-life care. Data shared in Chapter Four also illustrates that, in the African-American community, the pastor is regarded as a significant community figure. It would be useful for clergypersons to be well versed in end-of-life care. Should pastors not feel comfortable or competent in offering seminars, they can use their positions to facilitate community conversations. Persons who serve as key individuals in end-of-life conversations include helping professionals such as social workers, nurses, hospice care providers, and chaplains.

Limitations of the Project

Although the feedback was generally positive, the project was limited. There was no data from parishioners or patients to share what their true end-of-life needs or preferences might be. The survey did not ask what the information meant to the

participant. One of the primary limitations to this project is that the long-term influence of the training is not assessed, discussed, or included.

This project was also limited by not including family caregivers. Caregivers are the heart and soul of end-of-life care. In addition to the physical labor, caregiving may be spiritually challenging. Exploring the spiritual dynamics of caregiving may also be vitally important to increasing awareness of needs and highlighting necessary resources.

Thoughts for Future Research

This project was a beginning to a conversation that may increase dialogue and participation by ministers in end-of-life care discussions. While participants in the study received practical insights into pastoral care principles, participants were not asked to implement them in ministerial practice and then be surveyed. An area for consideration for future projects is to have ministers implement pastoral care principles and then have parishioners surveyed to determine the ministers' effectiveness. A survey following implementation of care principles may prove that the principles shared in this seminar were effective in theory and practice.

Several studies future studies emerge out of this research. A study could be conducted to analyze member response to the pastor conducting of end-of-life care seminars. A study may be conducted that samples a larger number of cultures and religions regarding end-of-life care conversations. Further research could be done on the use of pastoral assessments in ministry at the end-of-life.

I would suggest a continuing conversation between pastors and conference departmental directors, who have an opportunity to address educational deficiencies with financial resources for pastors. This would move the conversation for continuing

education toward a full product. Seventh-day Adventist ministerial directors may be able to encourage pastors to seek out further education that would help them provide more effective and meaningful care to those in need.

This project afforded me the opportunity to critically engage a topic that is meaningful to me. As a pastor, I found that assisting families at the end-of-life was a significant growing edge for me. Through my own pastoral care experiences, I discovered tools that not only assisted me, but could potentially help others. Through the course of this project, I have learned that there is still infinitely more to discover as it relates to end-of-life care. My hope is to be able to equip others with more tools to meet today's challenges in the parish, community, and beyond.

Appendix A

Informed Consent Form

Claremont School of Theology

Institutional Review Board

Informed Consent for Participation in a Research Study

Principal Investigator : Juleun A. Johnson

Study Title: Pastors As Caring Bridge Builders in Health Care Settings

Date: September 1, 2014

Name of participant: _____ **Age:** _____

The following information is provided to inform you about the research project and your participation in it. Please read this form carefully and feel free to ask any questions you may have about this study and the information given below. You will be given an opportunity to ask questions, and your questions will be answered. Also, you will be given a copy of this consent form.

Your participation in this research study is voluntary. You are also free to withdraw from this study at any time without penalty. In the event new information becomes available that may affect the risks or benefits associated with this research study or your willingness to participate in it, you will be notified so that you can make an informed decision whether or not to continue your participation in this study.

1. Purpose of the study:

The purpose of the study is: to demonstrate that Seventh-day Adventist pastors who receive orientation to end-of-life issues and healthcare communications become more effective advocates for church members and build bridges between the parish and healthcare professionals.

You are being invited to take part in this research because I feel that your experience as a minister can contribute much to the understanding and knowledge effective ministry practices.

2. **Duration of participation for the subject:** The subject's investment is 10-15 minutes for pretest and posttest, and a half hour for the seminar. The total duration of participation is 1 hour.
3. **Experimental Procedures:** There are no experimental procedures involved in this study.
4. **Description of the discomforts, inconveniences, and/or risks that can be reasonably expected as a result of your participation in this study:** There are **no risks** that are involved in this study.
5. **Foreseeable or anticipated risks from participation in this study:** There are **no foreseeable risks** involved in this study.
6. **Compensation in case of study-related injury:** There is no compensation of study related injury by the investigator.
7. **Good effects or benefits that might result from this study:**
 - a) Participants may be better equipped with knowledge to implement during end-of-life ministry and crisis.
 - b) Being able to communicate better with congregants and the community during end-of-life and health care crisis.
8. **There are no alternative treatments applicable to this project.**
9. **Compensation for participation:** There is no compensation for this project from the investigator to the participant.
10. **Circumstances under which you may withdraw you study participation:**
 - a. If a participant for any reason chooses to withdraw from this study they may do so without penalty.
 - b. If you as a participant choose to withdraw from the research please do the following. Please email the investigator at juleunj@gmail.com and request to be withdrawn from this project. You may withdraw at anytime without penalty from this project.
11. **Confidentiality:**

All efforts, within reason, will be made to keep your personal information in your research record confidential. Informed consent forms will be shared with those on the research committee. Once forms are sent back to investigator, the investigator will collect forms for D.Min. committee members for review during project process. Upon satisfactory completion of D.Min. project informed consent forms and all data may be kept by institution. At all times

through the course of this study the principal investigator Juleun A. Johnson will have access to the informed consent form.

12. Privacy:

Your information may be shared with the Claremont School of Theology Institutional Review Board or the Office of Human Research Protections (Federal Government). Your information will only be used for monitoring purposes.

13. Procedure for paperwork regarding consent. All participants will receive emailed copies of consent forms. Participants are asked to electronically sign consent forms and email them back to Juleun A. Johnson @ juleunj@gmail.com, the principal investigator.

14. Publication: There is the possibility that I may publish this study or refer to it in published writings in the future. In this event, I will continue to use pseudonyms and I may alter some of the identifying details in order to protect your confidentiality.

15. Contact Information.

If you should have any questions about this research study, please feel free to contact principal investigator Juleun A. Johnson at 918 Magnolia Blossom Court Apopka, FL 32712 205-789-8482 juleunj@gmail.com.

For additional information about giving consent or your rights as a participant in this study, to discuss problems, concerns, and questions, please feel free to contact the Claremont School of Theology Institutional Review Board Chair Dr. Tom Philips, 909-447-2500, and tphilips@cst.edu, 1325 N. College Ave. Claremont, CA 91711

Should there be further questions about the research please contact Dr. Belva Brown Jordan, Dean of Curriculum and Instruction 909-447-2500, bjordan@cst.edu, 1325 N. College Ave. Claremont, CA 91711

STATEMENT BY PERSON AGREEING TO PARTICIPATE IN THIS STUDY

I have read this informed consent document and the material contained in it has been explained to me verbally. All my questions have been answered, and I freely and voluntarily choose to participate. I have received a copy of this consent form.

Date (Month/Day/Year

Electronic of Signature of Participant

Consent obtained by:

Date

Signature

Juleun A. Johnson, Principal Investigator

Appendix B

Survey for Doctor of Ministry Project

PASTORS AS CARING BRIDGE BUILDERS IN HEALTHCARE SETTINGS

SURVEY

1. Gender

- a. Female
- b. Male

2. Ethnicity

- a. African-American
- b. Asian-Pacific Islander
- c. Caucasian
- d. Hispanic

3. Highest Educational Level

- a. Bachelor Degree
- b. Masters Degree
- c. Doctoral Degree

4. Years in Full-Time Seventh-day Adventist Ministry

- a. 0-5
- b. 6-10
- c. 11-15
- d. 16-20
- e. 21- 30
- f. 30 – AND ABOVE

5. Primary Full-Time Ministry Function

- a. Administrator
- b. Chaplain
- c. College/University Professor
- d. Departmental Director
- e. Pastor

6. Current Ministry Setting

- a. Rural

- b. Suburban
- c. Urban

7. When a crisis arises in your ministry do you feel equipped to provide a ministry assessment?

- a. Every time
- b. Often
- c. Sometimes
- d. Rarely
- e. Never

8. How often do you hold seminars in your church regarding grief recovery?

- a. Once a year
- b. Two times a year
- c. Quarterly
- d. Monthly
- e. Never

9. Kubler Ross's 5 stages of dying are an effective tool for assisting surviving relatives in grief recovery.

- a. True
- b. False
- c. I don't know

10. When someone dies in your ministry context, do you have a debriefing session with surviving parishioners?

- a. Every time
- b. Often
- c. Sometimes
- d. Rarely
- e. Never

11. How often do you communicate to those you serve about advanced healthcare directives?

- a. Once a year
- b. Twice a year
- c. Quarterly
- d. Monthly
- e. Never

12. Having your own advanced directive aids you in giving guidance about advanced care planning.

- a. True
- b. False

13. Having an awareness of more than one healthcare intervention assists you in helping those you serve in crisis.

- a. True
- b. False

14. There is a distinct difference between hospice care and palliative care.

- a. True
- b. False

15. Ministry of presence at the end of life is . . .

- a. Communicating with family members
- b. Praying over the parishioner after death
- c. Being with the family
- d. Silence
- e. Assisting in Funeral Arrangements

16. Being a pastoral bridge builder in healthcare settings means . . .

- a. communicating with the family regarding health diagnosis
- b. talking to the medical team on the families behalf
- c. supporting the family through a ministry of presence
- d. networking on the hospital unit for the benefit of the family

17. What has been the strongest trigger of grief in those you serve lately?

- a. birth
- b. death
- c. divorce
- d. loss of income

18. During a crisis are you likely to . . .

- a. hide your emotions
- b. act in a supportive role
- c. be a friend
- d. distance yourself from the family

19. When someone you serve dies, do you . . .

- a. honor their memory annually
- b. check on their surviving loved ones monthly
- c. do no follow up with their family
- d. pray for them periodically with no contact or voice or person-to-person contact

20. Please share the benefits and or usefulness of the information during this presentation to your ministry and context in the space below.

Appendix C

Webinar Presentation

Slide 1

**Pastors As Caring Bridge Builders
in Healthcare Settings**

By Juleun A. Johnson
Claremont School of Theology
D.Min. Project Seminar

Slide 2

Goal for the Seminar

**To equip pastors with strategies to assist in
end-of-life and crisis care situations.**

Slide 3

Juleun A. Johnson

- Served as a Pastor in South Central Conference of SDA for 13 years.
- Pastored in rural, suburban and urban settings.
- Pastored: 1, 2, and 3 church districts
- In Alabama, Florida, and Mississippi
- Currently Staff Chaplain in Cardiology
 - Florida Hospital Orlando

Slide 4

Functions of Pastoral Care

Slide 5

4 Functions of Pastoral Care

1. Sustaining

- Giving Support, comfort and understanding to help a person through a time of crisis whether small or great, short-lived or on-going.

2. Guiding

- Helping another person, either by direction, clarification or confrontation, to find solutions to problems or life's questions.

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Slide 6

4 Functions of Pastoral Care

3. Healing

- Aiding a person to find wellness or wholeness from brokenness, injury or disease.
- In pastoral care we usually mean brokenness, injury or disease in a spiritual and/or emotional sense.

4. Reconciling

- Helping a person to restore a relationship that has been broken either with a person, a group of people, or God.

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Slide 7

My Introduction to Crisis Care: My Story

Slide 8

Introduction to Crisis Care

- In my first pastoral assignment I was called to a family whose child was paralyzed as a result of a major accident.
- One Sabbath after church I was the one given to assist the family in understanding the conversation with the physicians.
- I had the sad task of sharing with the family that the daughter would never walk again.

Slide 9

Crisis Ministry

- What can be said of my experience was the fact that I had been a seminary graduate.
- In undergrad as a theology student I had been told that pastoral visitation was a primary function of the pastor.

Slide 10

Visitation

- What I realized post that crisis in my first district I had been trained to preach, educate, administer sacraments. But I had never been trained to visit people or respond in crisis.
- I had been trained to socially visit people.
- Once I had my Clinical Pastoral Education (CPE) Training I realized I had missed so many opportunities to grow deeper with my congregants.

Slide 11

Crisis Ministry

- I was trained as a theologian and preacher.
- According to the General Conference Education Department the core curriculum for theology students only requires 2 classes related to nurture.
- Pastoral care and Counseling and Marriage and the Family. Other classes related to nurture are electives.

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Slide 12

My Journey

- It was not until my first unit of CPE that I realized that my perspective on ministry was one sided.
- I was focused on discipleship and evangelism and less on healing and reconciliation.
- Pastoral care principles provide opportunities for healing and restoration of families and congregations.

Slide 13

Skills that can be translated from Clinical Setting to Parish

Slide 14

Transferrable Skills

- There are many skills that are transferrable in chaplaincy to the parish they include:
- Presence
- Visitation
- Assessment
- Active Listening

Slide 15

Ministry of Presence

- The words, "I have come to be with you," can help to provide comfort during your ministry of presence.
- This ministry may be a difficult one for some.
- Presence also includes silence, which may include lengthy periods without words.
- In short, being present includes being mentally engaged and willing to minister to a need.

Slide 16

Crisis Care in Hospitals

- The first goal of crisis care is to communicate willingness to share the experience.
- Something as simple as saying: "I have come to be with you," is powerful. This statement evokes, presence, meaning and trust.
- Too often pastors are too wordy and some times too uncomfortable with silence.

Slide 17

Visitation

- Visitation is a time to connect with those you are serving. Visitation is also an opportunity to be able to listen to different needs.
- Two types of visits will be discussed on the next slide.
- Social Visits and Pastoral Visits.

Slide 18

Social Visits Vs. Pastoral Visit

- | | |
|---|---|
| <ul style="list-style-type: none">• Social Visits• Have Time Parameters• Primarily Surface Conversation• A sprint• Allows for flow of topic• Is led by the listener• Is based on the context | <ul style="list-style-type: none">• Pastoral Visits• Open ended• Move to deeper levels• A Journey• May be the only time you experience a person• Uses Assessments• Is led by the care provider |
|---|---|

Slide 19

Visitation and Crisis

Slide 20

Kubler Ross 5 Stages of Death and Dying

- Kubler Ross originally applied these stages to people suffering from terminal illness, later to any form of catastrophic or personal loss (job, income, freedom).
- This may include life events such as death of a loved one, divorce, drug addiction, the onset of a disease or chronic illness, infertility diagnosis, as well as many other tragedies and disasters.

THE UNIVERSITY OF MICHIGAN
HOSPITAL & HEALTH CARE SYSTEM

Slide 21

5 Stages of Death and Dying

- *Denial and isolation: "This is not happening to me."*
- *Anger: "How dare God do this to me."*
- *Bargaining: "Just let me live to see my son graduate."*
- *Depression: "I can't bear to face going through this, putting my family through this."*
- *Acceptance: "I'm ready, I don't want to struggle anymore."*

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Slide 22

Debriefing Sessions

- Debriefing Sessions are an effective way to allow for communal grieving.
- Sessions may occur
 - In place of a Wednesday night prayer meeting.
 - At the repast of the funeral
 - At the home of the deceased
 - On Sabbath Following the worship Service
- Dual goal to allow people to talk and get comfort from each other.

Slide 23

Insights via Visitation

- An assumption may be that a long time member may be spiritually strong enough to deal with the loss of a child or grand child.
- What is useful in learning about someone's experience is asking the question –
 - What is this experience like for you?
- The words “for you” offer an invitation for the other person (s) to speak and share their experience.

Slide 24

Advanced Directives

Slide 25

Statistics for Advanced Directives

- Only about 30% of all people in America have an advanced directive.
- LaCrosse, Wisconsin is different 96% of all people in that city have an advanced directive.
- The difference is education people were prepared.

Slide 26

Advanced Directive

- An advance directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.
- Two Types
 - Durable Power of Healthcare attorney
 - Living will

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Slide 27

Advanced Directives

- In a durable power of attorney for health care, a person designates a trusted family member or friend to make health care decisions for you if you are unable – either temporarily or permanently – to do so for yourself.
- Most people think such a document is only for those who are very sick or very old. That's not true. It's absolutely essential for anyone who is 18 years old or older.

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Slide 28

Advanced Directive Decisions

- To place on life support
- To remove from life support
- To have a Do Not Resuscitate Order
- To have a Limited DNR only ventilation
- To allow Natural Death
- Organ Donation

Slide 29

Advanced Directive: Living Will

- Most declarations instruct an attending physician to withhold or withdraw medical interventions from its signer if he/she is in a terminal condition and is unable to make decisions about medical treatment.
- Done by physicians who have little connection to you or your patient/member.

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Slide 30

Assessments

Slide 31

Assessments

- Spiritual Assessments provide useful guidance for pastor and chaplain to use, to direct care.
- Some people many find doing spiritual assessments difficult because assessments require confrontation.
- Assessments seek to:
 - Identify significant relationships
 - Identify meaning and purpose for the person
 - Seeks to assist a person in applying meaning and or persons beliefs to a medical condition or situation in life.

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Spiritual Assessments

- Spiritual Assessments assist in helping a person to authentically share emotions and feelings associated with an event, diagnosis, or life change.

Slide 33

SMC Assessment

- I use the assessment SMC. As both pastor and chaplain I do not assume a person is spiritual just because they attend church.
- Spirituality
 - Where are you in this ?
 - Where do you see God at work in this experience?
- Support
 - What support do you have?
 - How has that support been for you?
 - Do you have access to the resources needed to meet your present or long-term health challenge?

Slide 34

SMC Assessment

- Meaning
 - What is it like for you to lose your hair?
 - What does it mean for you not to have the support of your family?
 - What do you feel when you think of your loved one?
- Coping
 - Coping
 - What is helping you to cope today?
 - Are you angry with God?

Slide 35

Health Care Interventions

- Breathing Machines
- Counseling
- Food
- Therapy: Psychiatric, Physical, Occupational
- Prescription drugs
- Screening tests to rule out diseases

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Slide 36

End of Life Care

Slide 37

End of Life Care

- End of life care is about the total care of a person with an advanced incurable illness and does not just equate with dying. The end of life care phase may last for weeks, months or years.

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Slide 38

End of Life Care Defined

- End of Life Care is defined as care that helps those with advanced, progressive, incurable illness to live as well as possible until they die.

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Slide 39

Goal of End of Life Care

- A goal of end of life care is built on the philosophy of axiology. That is to say what is of value?
- End of life care seeks to assist patients, families, and caregivers to make meaning of their life near death.
- End of life care addresses brokenness of people and seeks to reconcile life's choices prior to death.

Slide 40

Good questions to ask

- What do you need to do before you die?
 - This can mean letters, conversations, or making funeral plans
- Who do you need to forgive?
- What will you miss most?
- How would you like to be remembered?

Slide 41

Follow the Lead

- This is not a time for doctrinal inquiry about heaven or hell.
 - The goal is presence, not religious assurance.
 - Can you through a question guarantee eternal life?
- Let the patient/church member bring up a conversation about heaven or hell.

Slide 42

End of Life Care

- Hospice and Palliative care are helpful caregiving options for loved ones near the end of life.
- Being knowledgeable and conversant on end of life care measures with parishioners may give parishioners more comfort.

Slide 43

Hospice

- Hospice - Hospice focuses on caring, not curing and in most cases care is provided in the patient's home.
- Hospice care also is provided in freestanding hospice centers, hospitals, and nursing homes and other long-term care facilities.
- Hospice services are available to patients of any age, religion, race, or illness. Hospice care is covered under Medicare, Medicaid, most private insurance plans, HMOs, and other managed care organizations.

www.hospicefoundation.org
www.hospicecare.com
www.hospicecare.org

Slide 44

Palliative Care

- Palliative care is treatment that enhances comfort and improves the quality of an individual's life during the last phase of life or chronic illness. No specific therapy is excluded from consideration.
- The expected outcome is relief from distressing symptoms, the easing of pain, and/or enhancing the quality of life.
- The decision to intervene with active palliative care is based on an ability to meet stated goals rather than affect the underlying disease.

www.palliativecare.org
www.palliativecare.com
www.palliativecare.org

Slide 45

Hospice Vs. Palliative Care

- Hospice
 - Comfort care at home or at a skilled care facility for those who are known to have a poor quality of life or have reached their limit of life prolonging medical measures.
- Palliative Care
 - A treatment plan or agreement with a team that will include measures to prolong and or enhance quality of life in conjunction with caregiver and medical team.

Slide 46

Practical Spiritual Resources For Crisis Care

Slide 47

Prayers for all seasons

- Guide to praying prayers
 - Ask the person or group what they would like to be prayed for?
 - Since the goal is presence not being God your goal must be to present the person's request to God.
 - The goal is not to present your thoughts of their need to God.
 - That is judging

Slide 48

How to respond to a death at the Hospital or Hospice Care Facility

- Relax
- Minister to the Living
- Pray silently asking what God would have you do in the room.
- Listen and entertain stories about the dead
- Do not hide your emotions

Slide 49

How to respond to a death at the Hospital or Hospice Care Facility

- The goal is presence not superiority
- Family may need assistance in selecting a funeral home.
- The nurse is your best friend, they are there to assist you.
- This is not a time for a doctrinal study on the state of the dead.

Slide 50

Contact Following a Loss

- Following a death, surviving members still need comfort
- Follow up methods include:
 - Annual Remembrance services
 - Calls
 - Texts
 - Visits to both members and non members
 - Grief support groups

Slide 51

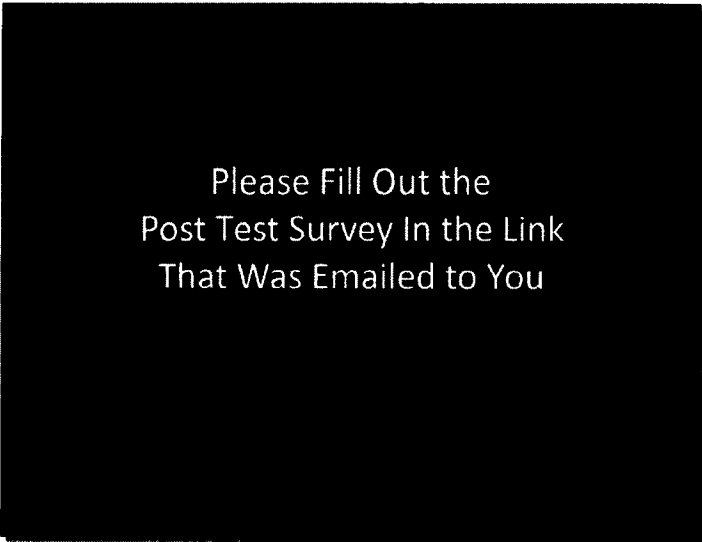
Ways to Honor Loss

- Recognize Widows/Widowers During Holidays (Valentines, Memorial Day, Christmas)
- Plant trees at church
- Establish endowments in honor of person
 - Annual Musical
 - Educational
 - Scholarships
- Name a portion of church building after person – fellowship hall, lobby

Slide 52

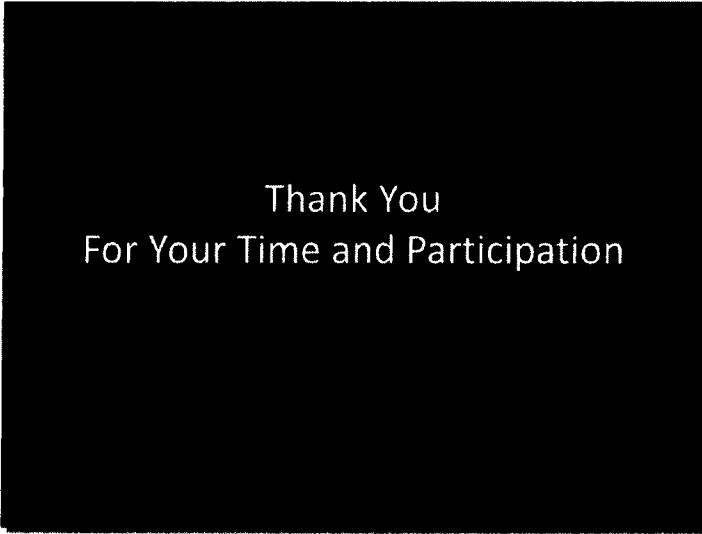
“I don't want my life to be defined by what is etched on a tombstone. I want it to be defined by what is etched in the lives and hearts of those I've touched.”
—Steve Maraboli

Slide 53



Please Fill Out the
Post Test Survey In the Link
That Was Emailed to You

Slide 54



Thank You
For Your Time and Participation

Slide 55

Carve your name on hearts, not
tombstones. A legacy is etched into
the minds of others and the stories
they share about you.
—Shannon L. Adler

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